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THE WARRIOR'S PROVIDER FROM BOOTCAMP THROUGH DISCHARGE: EDUCATING AND TRAINING AN ARMY OF SOCIAL WORK STUDENTS TOWARDS CLINICAL AND CULTURAL COMPETENCE WITH SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

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Abstract
Social workers are expected to serve, communicate, and interact effectively with a broad range of clients across various cultural contexts. Military culture is unique in that it puts the mission first, above one's life, family, and personal comfort. Military culture has its own beliefs, language, values, and legal system that significantly impact the use of healthcare practices. There has been recent research identifying the significant gap in knowledge and training for behavioral health providers serving military members, veterans, and their families. In 2014, a survey examining behavioral health providers in Maryland identified significant gaps in knowledge and confidence for providers assessing and treating clients with military experience (Koblinsky, Leslie, & Cook). Additionally, the RAND Corporation examined community based providers' capacity to deliver culturally competent, quality mental health care to veterans and their families (Tanielian et al., 2014). The findings highlighted that few civilian providers are prepared to serve military members, veterans, and their families. Only 13 percent of surveyed civilian providers met all the readiness criteria, and those that met these criteria did not necessarily meet the other threshold for providing the best evidence-based care (Tanielian et al., 2014). This dissertation briefly explores the history of military social work both in active duty and civilian settings. It provides an introduction to military culture and social work practice, seeking to identify the unique culture of each branch of service and its impact on the psychosocial health of our service members and their families. It aims to thoroughly examine the National Association of Social Workers (NASW) code of ethics and many ethical dilemmas social workers encounter serving this unique population. It addresses dual loyalty and mixed agency concepts, educating students on how the social worker is tasked to maintain allegiance to the military and the profession. It critically examines and addresses both legal and moral contexts for ethical dilemmas in active duty and veteran social work settings. The dissertation examines the veteran's developmental processes, predisposing factors, and vulnerabilities that often exacerbate military related trauma. Finally, it identifies the copious amounts of transitional resources available to our nation's veterans and the many social work implications. The primary objective of the dissertation is to create a military social work graduate certificate program guided by the Council on Social Work Education Core Competencies and Practice Behaviors. The graduate certificate program will include three elective courses designed to fulfill requirements of the MSW program and specified field placement experiences. This format will allow students to complete their MSW and military social work graduate certificate program simultaneously with no additional coursework required.

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ABSTRACT

THE WARRIOR'S PROVIDER FROM BOOTCAMP THROUGH DISCHARGE: EDUCATING AND TRAINING AN ARMY OF SOCIAL WORK STUDENTS TOWARDS CLINICAL AND CULTURAL COMPETENCE WITH SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

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Social workers are expected to serve, communicate, and interact effectively with a broad range of clients across various cultural contexts. Military culture is unique in that it puts the mission first, above one's life, family, and personal comfort. Military culture has its own beliefs, language, values, and legal system that significantly impact the use of healthcare practices. There has been recent research identifying the significant gap in knowledge and training for behavioral health providers serving military members, veterans, and their families. In 2014, a survey examining behavioral health providers in Maryland identified significant gaps in knowledge and confidence for providers assessing and treating clients with military experience (Koblinsky, Leslie, & Cook). Additionally, the RAND Corporation examined community based providers' capacity to deliver culturally competent, quality mental health care to veterans and their families (Tanielian et al., 2014). The findings highlighted that few civilian providers are prepared to serve military members, veterans, and their families. Only 13 percent of surveyed civilian providers met all the readiness criteria, and those that met these criteria did not necessarily meet the other threshold for providing the best evidence-based care (Tanielian et al., 2014). This dissertation briefly explores the history of military social work both in active duty and civilian settings. It provides an introduction to military culture and social work practice, seeking to identify the unique culture of each branch of service and its impact on the psychosocial health of our service members and their families. It aims to thoroughly examine the National Association of Social

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Key Words: Military Social Work, Curriculum, Certificate program, Military Culture

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Introduction

The United States Department of Defense established military social workers over 50 years ago and currently includes greater than 500 active duty military social workers and many additional civilian social workers assigned to various military components (NASW, 2012). In addition to active duty components, social workers serve many roles within the Veteran Affairs Administration, non-profits, and community organizations serving veterans and their families. Client needs are complex and the need for social workers who are properly educated, trained, and skilled in working with this population has significantly increased, making the demand even more critical (NASW, 2012). Military members, Veterans, and their families will continue to seek care in both the Veteran Affairs Administration and many additional community agencies. It is our national priority to provide high quality cultural and clinically competent care. In 2015, Canfield and Weiss published a journal article focusing on the lack of military social work curricula and the need to integrate military and veteran culture in social work education, noting the following:

> Despite the evident need and professional call for increased military content to be infused into social work education, from informal surveys from schools of social work around the nation, there is little content in most social work curricula concerning the effect of the military lifestyle, culture, and the unique experiences of veterans and military connected families. Most of the content that is delivered in social work education (if any content on service members or veterans and their families is provided) tends to link veterans with posttraumatic stress disorder (p. 130).

As our nation's veterans continue to return home and reintegrate back into the civilian sector, social workers will be in high demand and called to serve this population in a variety of ways and settings.

The primary aim of the graduate certificate program is to minimize the significant gap in knowledge and training the recent research has so importantly addressed and highlighted. Canfield & Weiss (2015) introduce the notion that there is perhaps no better group of individuals that can educate, inform, and create awareness of a social problem affecting a community than social work leaders, educators, and community providers (p. 141). The military social work certificate program is designed to offer specialized training and education through a unique cohort model. Students will not only enhance their learning through classroom instruction and training modules but gain maximum benefit from conducting their field placements in an agency working directly with military members, veterans, or their families.

At the culmination of the graduate certificate program, students will have historical and contemporary knowledge of military culture and social work practices with service members, veterans, and their families. They will have increased knowledge and understanding of ethical dilemmas social workers encounter in a variety of settings. They will have demonstrated advanced understanding of evidence based treatment modalities, the effects of trauma on the entire military family unit, and how to build and cultivate resilience in military families. Students will explore all aspects of military related trauma; such as, military sexual trauma, posttraumatic stress disorder (combat and non-combat related), domestic violence, and additional traumatic stress reactions unique to this population.

Students will become familiar with veteran social work practice to include transitional care services and the reintegration process. This will include but not be limited to: the Veterans

Affairs System, service connected disability compensation, Post 9/11 GI Bill, educational benefits, home loans, and the available non-profit/community agencies providing integrated care for service members, veterans, and their families. Students will be able to identify the various systemic, psychological, and organizational barriers to care. They will develop a thorough understanding of the ongoing psychosocial issues veterans and their families encounter when they are no longer serving on active duty status and have officially been discharged from the military and placed into veteran status. Students will be able to understand the epidemiology of suicidal thoughts and behaviors, substance use disorders, homelessness, and how social workers provide integrated mental health care as part of a multidisciplinary team.

Part 1: A Basic Overview of Military Culture and Social Work Practice

CHAPTER 1: The Current State of Military Social Work Education

A comprehensive review of the literature was conducted in order to identify and address the gap in social work education and specialized training required for social work students who intend to provide social work services and ongoing care for military members, veterans, and their families. A critical exploration of the existing and predominantly recent literature proves the pressing need to develop and infuse military and veteran social work curricula at the bachelors, masters, and doctoral levels.

There are few institutions of higher learning that have incorporated military and veteran social work into their coursework; however, "this disparity in the educational process across schools of social work leads to divergent competencies concerning a population with a unique culture and clinical presentation" (Canfield & Weiss, 2015, P. 128). The military has its own command structure, health care system, legal system, beliefs, language, and set of values. This requires social workers to be properly educated and trained to provide clinically and culturally competent care for service members, veterans, and their families. According to Luby (2012), providers who develop a basic understanding of military values, show significant improvement in offering competent care specific to military culture, ultimately improving the therapeutic relationship.

Social work students, who plan to focus primarily on working with military members, veterans, or their families, often apply for internships within the Veterans Affairs Administration and its affiliated associations or non-profit agencies. The Veterans Affairs Administration is the largest employer of master's level social workers in the United States. In addition, there are social workers providing care across the Department of Defense (DOD). They are employed to

fill multiple roles within the DOD, to include serving as commissioned officers on active duty status, reservists, contractors, and government series workers. Social workers in the DOD may be tasked to provide care and services in the areas of mental health, substance abuse, domestic violence, family support, deployment readiness, and military sexual assault. However, social workers are not limited to serving this population directly in government settings; they provide care for military members and veterans in many community based healthcare and non-profit agencies. Veterans often receive services outside the Veterans Affairs system; whether it is homeless services, mental health care, substance abuse, or education and employment retraining. Military members will undoubtedly return to the civilian sector and become an integral part of the social fabric in local communities, requiring competent resource providers to be sensitive and willing to learn about military culture and continually applying the professional practice standards to the military and veteran population (Luby, 2012).

Students who do not seek out specialized internships or coursework with the military and veteran population, still require the basic skillset in order to be able to provide competent and ethical social work services in the many community based agencies providing services to military members and veterans (Canfield & Weiss, 2015, 2015). Luby (2014) addresses the need to adapt care to military culture, with some studies suggesting service members, veterans, and their families respond positively to military affiliated providers or those providers who attempt to better understand their unique culture. “In practice, sensitivity to these values establishes a critical link from the civilian-based service provider to the military client” (Luby, 2014, p. 70).

There is a clear distinction between traditional psychotherapy and military mental health care. This distinction highlights the systemic and organizational stigma often preventing military members from accessing appropriate mental health care treatment. With the military mission

being the primary objective, the veteran's perception of mental health treatment and therapy services may be the first challenge needing to be negotiated, as the veteran may see self-growth as self-indulgent and in return exacerbating the stigma associated with psychotherapy (Canfield & Weiss, 2015). Olson (2014) speaks to the connection between macro practice and micro issues in military social work content, addressing the importance of "exploring how structural and positional factors affect military personnel can increase students' recognition of the interplay between macro and micro issues" (p. 183). Olson (2014) powerfully acknowledges the critical need to utilize social work perspectives in expanding the student's view of problems far beyond the simplistic psychological justifications.

In 2014, the Council on Social Work Education (CSWE) published its annual report on *CSWE Statistics on Social Work Education in the United States*. The annual survey is primarily collected online and is the primary source of information about social work students, programs, graduates, faculty, and administrators. "In addition to advancing knowledge about social work education, the data are used to determine membership dues for accredited baccalaureate and master's programs (CSWE, 2014, p. 2). Illustration 1 (Table 29) below provides the field placement category for Baccalaureate students, indicating 105 students who were working directly in the field of military social work at the baccalaureate level. Of the 462 programs reporting, 0.6% of their students were working in the field of military social work.

Illustration: 1

Table 29. Field Placements of Baccalaureate Students by Category

Field Placement Category	Number	%
Child Welfare	2,898	15.9
School Social Work	1,827	10.0
Family Services	1,802	9.9
Aging or Gerontological Social Work	1,618	8.9
Health/Integrative Health & Mental Health	1,538	8.4
Community Mental Health or Mental Health	1,477	8.1
Corrections or Criminal Justice	922	5.1
Addictions/Physical Dependence; Alcohol, Tobacco, & Other Drugs	900	4.9
Displaced Persons/Homeless	833	4.6
Domestic Violence or Violence	815	4.5
Developmental Disabilities	594	3.3
Public Assistance/Public Welfare	455	2.5
Community Development or Planning	450	2.5
Advocacy	297	1.6
Immigrant/Refugee Work	246	1.3
Occupational Social Work or Rehabilitation	194	1.1
Social Policy	114	0.6
Military Social Work	105	0.6
LGBTQ	101	0.6
Post-Traumatic Stress Disorder/Veterans	97	0.5
Global/International Social Work	96	0.5
Administration	68	0.4
Program Evaluation	31	0.2
Other	777	4.3
Total	18,255	
Programs reporting	462	

(CSWE, 2014, p. 26).

However, as indicated in illustration number 2 (table 33) below, there are a total of 9 certificate programs being offered at the master's level in the field of military social work, amounting to 4.0% of the 224 programs reporting to CSWE. Many of the certificate program topics being offered as indicated in table 33 can be covered throughout the military social work certificate program. For example, many military service members, veterans, or their families receiving care at VA, DoD, or community agencies fit into the categories of aging/gerontology, addictions/substance abuse, child welfare, trauma, health care, and clinical.

Illustration: 2

Table 33. Certificates Offered by Master's Programs

Certificate	Programs Offering	
	Number	%
Aging/Gerontology	56	25.0
School Social Work	45	20.1
Addictions/Substance Abuse	26	11.6
Child/Adolescent Welfare	18	8.0
Nonprofit Management	18	8.0
Trauma	15	6.7
Global/International/Refugee	14	6.3
Health/Health Care	11	4.9
Clinical	10	4.5
Gender or Women's Studies	10	4.5
Military Social Work	9	4.0
Disabilities	8	3.6
Human Services Management	6	2.7
Family & Marriage	5	2.2
Jewish Services	4	1.8
Other	34	15.2
Programs Reporting	224	

(CSWE, 2014, p. 29).

Illustration 3 below (table 35) indicates a relatively large number of students enrolled in the military social work concentration or specialization offered by master's programs, however, there are only 8 programs nationwide (4.2%) that actually offer a military social work concentration. This statistic indicates a large number of master level students enrolling into the military social work concentration or specializations offered by master's program. Although this statistic seems to show that master level students are highly interested in enrolling in the military social work concentrations or specializations, the number of programs is extremely limited and does not provide access to those master level students who may be interested in gaining knowledge and training in the field of military social work.

Illustration: 3

Table 35. Student Enrollment in Concentrations or Specializations Offered by Master's Programs

Concentration or Specialization	Enrollment	Programs Offering	
		Number	%
Clinical	14,025	61	31.8
Advanced Generalist	5,703	50	26.0
Mental Health	2,899	35	18.2
Children or Youth	2,367	37	19.3
Families	1,788	25	13.0
Community	1,225	26	13.5
Health	1,120	23	12.0
Administration	852	29	15.1
Trauma	833	5	2.6
School Social Work	633	24	12.5
Military Social Work or Veterans Services	569	8	4.2
Aging or Multigenerational	493	28	14.6
Leadership	382	7	3.6
Multicultural	310	2	1.0
Addictions	258	14	7.3
Nonprofit or Public Management	233	9	4.7
Policy	190	10	5.2
Integrated Health or Behavioral Health	126	4	2.1
Immigrants or Refugees	83	4	2.1
Rural	70	2	1.0
Global or International	57	4	2.1
Disabilities	14	4	2.1
Research	7	1	0.5
Other	5,709	56	29.2
Programs reporting		192	

(CSWE, 2014, p. 31).

Illustration 4 continues to highlight the number of students serving military populations (591). As veterans continue to reintegrate back into the civilian sector, this number will likely rise, as the demand for social work services increases. In addition, students who may not be intentionally placed in the military social work field encounter veterans and their families in many of the community based agencies, further demonstrating the need for military content in schools of social work.

Illustration 4:

Table 36. Field Placements of Master's Students by Category

Field Placement Category	Number of Students	% of Students
Community mental health or mental health	7,032	18.7
Health/integrative health & mental health	5,324	14.1
School social work	4,467	11.8
Child welfare	3,698	9.8
Family services	3,317	8.8
Aging or gerontological social work	1,996	5.3
Addictions/physical dependence; alcohol, tobacco, & other drugs	1,963	5.2
Community development or planning	1,073	2.8
Corrections or criminal justice	1,056	2.8
Domestic violence or violence	1,056	2.8
Displaced persons/homeless	934	2.5
Developmental disabilities	730	1.9
Military social work	591	1.6
Post-traumatic stress disorder/veterans	573	1.5
Administration	496	1.3
Immigrant/refugee work	478	1.3
Advocacy	370	1.0
Social policy	308	0.8
Public assistance/public welfare	273	0.7
LGBTQ	214	0.6
Occupational social work or rehabilitation	211	0.6
Global/international social work	118	0.3
Program evaluation	105	0.3
Other	1,316	3.5
Total	37,699	
Programs reporting	211	

(CSWE, 2014, p. 32).

In 2009, Savitsky, Illingsworth, & DuLaney addressed the goal of compelling civilian social workers to acknowledge their responsibility of competently serving this population and how "social work organizations have failed to emphasize or disseminate information and tools to aid social workers in assisting a population in need of social work services…universities preparing social workers have done little to integrate content on this special population into the social work curriculum" (p. 327). Social workers are uniquely positioned to address the many psychosocial issues and challenges our military and veterans are presented with on a consistent basis. In order to assist and intervene with this population, social workers must be able to understand basic military culture and customs. Social workers who have knowledge of the organizational structure and rank hierarchy across the many service branches and classifications will appreciate how their status affects the psychosocial issues to which military members and their family members may be exposed (Luby, 2012).

CHAPTER 2: A Brief History of Social Work Practice with Service Members, Veterans, and their Families

The significant role of the social worker is embedded throughout military history. Uniformed social workers have served in the Army, Navy, and Air Force. In addition, social workers have served all branches of the armed forces, to include reservists and National Guard members, in a civilian capacity through government and non-government agencies. Rubin & Harvie (2013) note that the profession has been linked to the military throughout history, as early as 1636 when "Pilgrims of Plymouth County stated that the care of disabled veterans was the responsibility of the colony" (p. 4). However, the Red Cross would not become a formal organization until the post-Civil War era, and began providing direct services to the American military during the 1898 Spanish-American War (Rubin & Harvie, 2013). "Many Red Cross services were provided by social workers during the Spanish-American War; consequently, the term military social work can be conceived as originating at that time" (Rubin & Harvie, 2012, p. 4).

Army Social Work

James Harris (2000) identified the vital role that the Red Cross and additional civilian social work agencies played in order to help develop and shape what is now Army social work. "Before there were uniformed social workers there were Red Cross Social Workers. The value of psychiatric social workers to the Army was made known during World War I…the first social worker was available for duty on September 1, 1918" (Harris, 2000, p. 3). However, the military did not acknowledge the social work profession as a designated military occupation until the end of World War II (Rubin & Harvie, 2013, p. 3). In October 1943, the War Department would publish the Military Occupational Specialty for Psychiatric Technicians, and it wasn't until 1945 when social workers would be considered commissioned officers (Harris, 2000). "The

psychiatric social workers were usually the first to interview the new recruit. It was recognized that a social worker in uniform had increased credibility and was in a better position to identify with his fellow soldier" (Harris, 2000, p. 9).

The shift from psychiatric social work to medical social work would become apparent in the early 1950s, as the Army would recognize social workers as providing services to non-psychiatric patients; however, social work would fall under several different frameworks, until 1966 when the "Surgeon General proclaimed that social work should have a separate service with Class II Hospitals" (Harris, 2000, p. 11). The social worker's role in the United States Army would continue to evolve; such as providing services through the stockade screening program, a program initially designed to rehabilitate military members who were confined, which led to the development of a Correctional Training Facility in 1968, and social workers would play a crucial role in its development (Harris, 2000).

Air Force Social Work

As the United States Army led the way for social work services in the military, the Air Force would follow suit in 1947, when social work would become its own military department, bringing with it many of the Army's organizational characteristics (Rubin & Harvie, 2013). The United States Air Force (USAF) formed a new corps within their Medical Service in 1965, transitioning social work from the Medical Service Corps to the Biomedical Sciences Corps, as we know it today (Jenkins, 2000).

> A masters in social work degree was the standard established for social work practice in the Air Force. A lack of quality control in the 1950s and 1960s resulted in some individuals with a master's degree in fields such as counseling occupying social work positions. However, by the early 1970's, all social workers had an

> MSW and many earned a PhD through Air Force Institute of Technology assignments to civilian graduate social work programs (Jenkins, 2000, p. 29).

The number of active duty social workers would rise rapidly; there were initially 6 commissioned social work officers serving in the entire USAF in 1952, reaching 90 in 1972 as a response to the Vietnam war, 120 in 1975 to meet the substance abuse program requirements, climbing to 173 in 1980 as there were additional requirements for child abuse programs, and in 1988 the total number of USAF active duty social workers reach 225 (Jenkins, 2000).

In addition to the unformed active duty social work officers, the 1980s-1990s would see a rise in civilian government series and contract workers. This rise would be in large part due to having to support the increasing demand for family advocacy services (Jenkins, 2000). Air Force social workers operated predominantly in mental health services for the first 20 years of the program, and has remained as a primary practice element for both uniformed and non-uniformed social workers to present day (Jenkins, 2000). The Air Force would establish a program in the mid 1960's known as Project Child Have a Potential (CHAP), initially as a way to provide administrative support to the special needs of military families, however, this would evolve into what is now known as the Exceptional Family Member Program (EFMP) in the mid-1980s, when the Department of Defense "assumed a more active role in standardizing these services among all military departments (Jenkins, 2000, p. 33).

Social Work services in the Air Force would continue to develop and expand outside its traditional mental health practice in the 1970s as a result of significant substance abuse issues amongst Vietnam Veterans, and social workers have continued to fulfill these roles during present day (Jenkins, 2000). Perhaps the biggest expansion of social work services was in the 1980s, when the Child Advocacy Program had been renamed the Family Advocacy Program in

order to address both child and spouse abuse, resulting in a shift outside of psychiatry and specific funds being allocated to the Family Advocacy Programs (Jenkins, 2000).

Navy Social Work

The Navy, similarly to the United States Army and then Air Force, would see social worker services evolve from the original tradition of the Red Cross providing social services to military members and their families, to the actual employment of social workers serving multiple roles within the Navy. Prior to WWII, the Red Cross would provide a small number of social workers to work at Naval medical centers, and by the end of WWII, the Navy Relief Society would eventually hire its first professional social worker to help Navy service members and their families (United States Navy Medical Service Corps, 2000).

Initially, the majority of social work services in the Navy were assigned to training volunteers during the WWII era, requiring assistance from many other professions (United States Navy Medical Service Corps, 2000). The Red Cross terminated their psychosocial services program in the 1970s, resulting in a decline in Navy Social Services, placing a heavy burden on nurses, physicians, psychologists, and other administrative support officers (United States Navy Medical Service Corps, 2000). However, the emotional toll of the Vietnam War would highlight the immense need for social services, especially for those families of prisoners of war and those missing in action, requiring support and counseling (United States Navy Medical Service Corps, 2000). “In 1972, a Center for Prisoner of War Studies was established at the Naval Health Research Center in San Diego, California. Its research concluded that strong outreach services, collaboration with other agencies, and mental health consultation were necessary to POW’s and their families. This led to social workers being employed at several Navy Treatment Centers” (Rubin & Harvie, 2013, p. 10). Similarly to the Army and Air Force, the addition of the Navy’s

Family Advocacy program would necessitate a dramatic increase in employed military and civilian professional social workers. The addition of the Navy Family Advocacy program would occur in 1979, and for the next 5 years the Navy would see a dramatic increase in social work services in Naval medical treatment facilities (MTFs), within the Family Advocacy programs, expanding mental health and drug and alcohol services (United States Navy Medical Service Corps, 2012). In the 1990s there were approximately 30 social workers in the Navy Medical Department, serving in a variety of ways, to include the first ever deployment of Navy Social Workers to a combat zone, providing mental health support services on board the hospital ships *Comfort* and *Mercy* (United States Navy Medical Service Corps, 2012).

Veterans Affairs Social Work

The social work profession has been an integral part of the Veteran's Health Care Administration since the American Civil War, where various churches and state and local groups would raise funds and provide countless services and moral support to service members, medical staff, and veterans (Department of Veterans Affairs, NA). There was no formal social work training or education that existed from 1866 until World War I, however, there were many forms of social work being performed in the areas of education, relationship building, and familial support as well as occupational, recreational, and religious activities for Veterans (Department of Veteran Affairs, NA). There would be a shift in VA health care that took place during World War I, and in 1918, psychiatric hospitals would become a new distinct type of Veterans medical facility, introducing the need for psychiatric social workers in VA Health care (Department of Veteran Affairs, NA).

Social work in the Department of Veteran's Affairs (VA) began with a general order by the Veterans Bureau in June 1926, with a total of 36 social workers working in psychiatric

hospitals and regional offices during the first year of staffing, initially only focusing on psychiatric and tuberculosis patents (Department of Veteran Affairs, 2012). The number of social workers would dramatically increase after the development of the Department of Medicine and Surgery in 1946, implementing medical research and school affiliated programs, with a VA annual report stating "the VA social service staff has increased from 550 in July 1946 to 1,026 in June 1947" (Department of Veterans Affairs, NA). The social service programs at VA were considered to be such a standard of high quality that 27 accredited social work schools placed 105 graduate students at the VA for their field placements (Department of Veteran Affairs, NA). Since its inception, the role of the VA social worker has continued to evolve and is now seen throughout numerous services provided by the Veterans Affairs Administration.

Social workers serve veterans and their families in the departments of vocational and psychosocial rehabilitation, implement treatment approaches for veterans experiencing social problems, care for the dying, address the needs of bereaved families, work with veterans with both acute and chronic medical conditions, provide continuity of care across the continuum from admission to follow-up, coordinate discharge plans, provide case management services, and engage with community resources for referral management (Department of Veterans Affairs, 2012). "Over the years, Social Work staff has addressed the needs of distinct Veteran populations, i.e., the homeless, the aged, HIV/AIDS patients, spinal cord injury, Ex-POWs, OEF/OIF, Vietnam and Persian Gulf Veterans and their families, etc."(Department of Veterans Affairs, 2012, p. 1).

According to the Department of Veterans Affairs (2012), the VA is associated with over 180 graduate schools of social work, training over 900 students per year. The VA has proven itself as a clear leader in developing social work leaders, and maintains one of the largest and

most comprehensive clinical training programs for master level graduate students in the country (Department of Veteran Affairs, 2012). As VA health care continues to evolve, so does the social work services the VA offers. The social work profession has continued to adapt to the shift in a traditional inpatient model to a more primary care based outpatient model, allowing the social work profession to play a key role in the delivery of services (Department of VA, 2012).

> The present thrust is such that broad community planning, coordination, and integration of services are becoming a reality on federal, state, county, and local levels. Decentralization, accessibility, relevancy, continuity, and effectiveness of service delivery are health care systems that continue to be perfected. Social work, because of its leadership, flexibility, and commitment to "Putting Veterans First", continues to thrive as a profession in the current health care environment (Department of VA, 2012, p. 1).

Chapter 3: The Relationship between Military Culture and Social Work Practice

Unlike the civilian sector, "the military, in the name of mission readiness, is highly involved in the personal lives of those who serve and is often concerned with intimate details, such as marital discord, substance abuse, and mental and physical health" (Savitsky, Illingsworth, & DuLaney, 2009, p. 29). The dual loyalty concept tasks the social worker with not only providing care for the client but also maintaining their allegiance to the military. The military provider is required to continually conduct fitness for duty evaluations and provide the member's commander with recommendations based on the intimate details discussed with the social worker in the clinical session. This requirement has the potential to exacerbate stigma associated with accessing mental health or other supportive counseling services, due to the potential for long-term career impact and challenges the profession's general sense of confidentiality.

The social worker is responsible for providing the service member's command structure with any potentially disqualifying information or suitability factors, duty limiting conditions to include recommending no access to firearms, and recommending suspension or permanent disqualification from sensitive and top secret job requirements. Service members diagnosed with certain mental health disorders can be deemed unfit for continued service, receive a medical evaluation board, and face potential permanent discharge from the military. This has far reaching implications on the service member, their family members, and society at large. This notion introduces many ethical dilemmas in integrating social work ethics and military social work practice.

It is critically important for military social work to be infused into the curriculum so social workers in training can explore the possible influence of military culture and the potential

effects on military members. Olson (2014) acknowledges the enduring relationship between social work and the military, noting the following:

> It is critical that educators consider the ethical challenges posed by the disparate cultures and philosophies of the two systems…it is essential that educators promote students' awareness of the systemic factors affecting service personnel and provide a theoretical basis for military content that is compatible with tradition and values of social work. (p. 184-185)

As a result of our nation's armed forces being at war for greater than a decade, the military and veteran population present with complex mental and physical health complications. This requires the social worker to interact with healthcare providers across a variety of disciplines. Within the Department of Defense (DoD), Veteran's Affairs Administration (VA), and community based agencies, "social workers have critical roles in behavioral health service provision to veterans and their families and thus need evidence-informed training and education about how to most effectively perform assessments and implement evidence based interventions that are militarily relevant" (Wooten, 2014, p. 7).

Wooten (2014) points out how military social work is distinctive, differing dramatically from generalized practice with civilian populations in that service members, veterans, and their family members reside, work, receive health care services, and social benefits in a "hierarchical, sociopolitical, environment within a structured military organization" (p. 8). Due to the many unique characteristics of the military, Wooten (2014) explains why military social work is a specialized field of practice and it is vital to incorporate this concentrated area in social work curricula. Wooten (2014) further explains that military social work is specialized due to the

overall organizational culture, high performance expectations, significant occupational hazards, and the increased personal demands to include maintaining good order and discipline.

In order to properly educate social work students regarding multicultural skill development, educators must examine any potential biases and preconceived notions, political implications, and religious belief systems, they may have concerning the military (Canfield & Weiss, 2015). Canfield & Weiss (2015) recommend the introduction of military and veteran subject matter experts from the surrounding community to come speak as guest lecturers in the classroom in order to proactively address the gaps in knowledge base of faculty at their respective schools of social work. In 2015, Alex Smith-Osborne designed a study consisting of 268 participants who completed an intensive continuing education certificate designed with companion military social work coursework. Smith-Osborne (2015) discussed findings that supported an implementation of a large scale and self-supporting military social work certificate as not only feasible but sustainable evidence based practice with military populations (p. 89). Smith-Osborne (2015) points out that standards were disseminated by the Council on Social Work Education in 2010 and National Association of Social Workers in 2012 that provide a structural framework; however, "it is the responsibility of individual social work education programs to design implementation strategies and enact them rapidly and economically" (p. 90).

Civilian social workers must obtain appropriate and adequate education on military culture, the range of psychosocial issues they encounter, and the many policies impacting service delivery. A large majority of social work students who are employed following graduation will come in direct contact and be tasked to provide services for military and veteran populations. Canfield & Weiss (2015) identify a variety of ways military social work can be infused into the four areas of foundational preparation in social work education: Social Work practice, Social

Welfare Policy, Research, and Human Behavior in the Social Environment (HBSE). They pose the notion that military members, veterans, and their families present with distinctive issues that can be integrated into the HBSE curricula, while many schools have coursework in diversity and cultural issues where military social work content could also be infused (Canfield & Weiss, 2015). The Council on Social Work education recognized the demand and developed a task force of uniformed and civilian social workers to define the necessary competencies in working with military and veteran populations in order to promote competent military social work, eventually culminating in the creation of the Advanced Social Work Practice in Military Social Work guidelines (Daley, Carlson, & Evans, 2015). Social work departments must "recognize their responsibility in preparing the next generation of social workers to serve this population by addressing their needs in development of curriculums, for the needs of service members, veterans, and their families will be pronounced for years to come" (Savitsky, Illingsworth, & DuLaney, 2009, p. 336).

The Role of the Uniformed Social Worker

The active duty social worker serves a dual role as a commissioned military officer serving both the military system and the individual client. Social workers have been operating within the military as early as World War I. The military social worker is obligated to put the military mission first. "By virtue of their binding commissioned identity, military providers are required to consider the superordinate military mission as a top priority. At times, the best interests of an individual service member must be temporarily ignored to achieve a broader mission" (Johnson, Grasso, & Maslowski, 2010, p. 548). The military system can be explored through Erving Goffman's theory of total institutions. "Total institutions are characterized by the bureaucratic control of the human needs of a group of people, and it operates through the mechanism of the mortification of self" (Goodman, 2012, p. 81).

Currently, social workers are serving in active duty status across many branches of the armed forces, encountering various ethical dilemmas. The active duty social worker can be seen wearing the uniform in the United States Army, Air Force, and Navy. However, uniformed social workers serve all members of the armed forces, their family members and retirees who have access to the military medical system. They serve in peace time and at war, both stateside and abroad, including deployed combat locations. Social workers are part of the social fabric and an integral part of military history. Social workers must have a fundamental understanding of the military experience and cultural influences on the service member, veteran, and their families. The military culture and lifestyle is unique and a distinct subset of American society, having its own traditions and values, and governed by a completely separate set of laws under the Uniformed Code of Military Justice (UCMJ) (Coll, Weiss, & Yarvis, 2011).

All active duty military social workers are also officers, wearing a uniform indicating their rank and position. The presence of a uniform alone can create barriers between the social work officer and the enlisted client. The military uniform may play a part in constructing the behavior of the military social worker, which could reinforce the power of the hierarchical system. The influence of military law and the commander on provider decision-making can be significant. Relating back to Goffman's theory on total institutions, totalizing can be related to the degree to which the service member is excluded from knowledge of the decision-making process concerning his/her treatment and career impact (Goodman, 2012). For instance, the military mental health model can place restrictions on self-determination and autonomy. If the mental health provider determines the service member to have a personality disorder, than the provider communicates the member's disorder to the commanding officer. The commanding officer then may proceed with the social worker's medical recommendation and determines

whether the member is no longer suitable for military service, potentially administratively discharging the member from military service. This concept is in line with Goffman's self-mortification and determinations resulting from the military's bureaucratic control.

The military does not allow much room for individual autonomy, however, the military places great emphasis on unit cohesion and mission oriented mindsets (Coll et al., 2011). This leads to the formation of a unique and separate society from the civilian sector. This intentional divide psychologically distances military members and often their families from the civilian sector. "Having been shaped by a pervasive military culture, individuals who leave the military after many years of service encounter the same type of culture shock that immigrants experience when first arriving to the United States; there is disorientation, change of status, and a search for identity and meaning" (Coll et al., 2011, p. 488).

The Conflict between Ethics and Law for the Uniformed Military Social Worker

The military social worker serves as a primary consultant to the service member's commanding officer. The social worker must inform the commander of any duty limiting conditions that may exist, creating tension within the therapeutic dyad, potentially having to break privacy and confidentiality in the best interest of the system and not the client. This may also lead to the client withholding significant amounts of information. Military social workers have to operate within their professional code of ethics and Department of Defense statutes, often having to select between "patient-centered therapeutic interests and organization-centered administrative interests" (Johnson, et al., p. 548). The connection between the macro and micro forces are apparent in military social work. Olson (2014) acknowledges the effects of macro forces in society, specifically the effects of socioeconomic class in the military. "Some critics have suggested that war has become more acceptable to middle- and upper-economic groups

because service personnel tend to be drawn predominantly from lower income populations" (Olson, 2014, p. 184).

The social work profession continues to be called upon to serve military systems in a variety of active duty settings. These include but are not limited to the following: alcohol and drug programs, suicide prevention programs, outpatient mental health programs, family advocacy programs, crisis intervention, resiliency initiatives, and disaster mental health response. As social workers continue to be called upon to serve these military systems, it is important to recognize the possibility of ethical compromise and cooptation, and this warrants greater scrutiny (Olson, 2015).

As a result of military settings being at increased risk for mixed-agency pressure, military mental health providers "may deliberately or inadvertently do several things to exacerbate the problem when ethics and law collide in the course of their professional practice" (Johnson, et al., 2010, p. 550). Johnson et al. (2010) highlights several important approaches that may exacerbate the problem with ethics and law. First, social workers may not be familiar with all of the military laws, Department of Defense instructions, regulations, and the National Association of Social Workers professional code of ethics. Military mental health laws and regulations are constantly in flux, requiring the social worker to remain cognizant of the changes and maintain adherence to the military mission and their profession, as they often conflict. Second, uniformed social workers may adhere to federal laws, instructions, and regulations in every scenario, without questioning the methodology or approach. Johnson et al. (2010) discusses this approach as the military manual approach, "such a provider will often fail to use patient-specific discretion in balancing obligations to laws and ethics" (p. 550). The final approach explained by Johnson et al. (2012) is the stealth approach, referring to the social worker silently ignoring the legal or

Department of Defense instructions in order to fully abide by the NASW professional code of ethics, often creating "unnecessary polarity between ethics and laws and may create considerable legal exposure for the provider (p. 550).

LGBT and the Military

As a result of historical military policies involving Lesbian, Gay, Bisexual, and Transgender (LGBT) populations, researchers have utilized varying terminology when referring to LGBT populations. As seen below, much of the research uses the term LGB or GLB as a result of the ban on transgender people being able to serve openly in the military. This will be sure to change as one of the final barriers to military service was lifted in 2016, allowing transgender people to serve openly in the United States armed forces. This will open the door to more research, discussions, and ultimately highlight the pertinent health care needs of the LGBT military populations. Moving forward and throughout this chapter I will refer to the population as LGBT, encompassing all individuals who have now been deemed legally allowed to serve openly in the United States Military.

To truly understand the LGBT population in the military, we must review their history. The military is a representation of the American people, however, that does not mean there haven't been struggles regarding equality and acceptance. LGBT populations have encountered struggles throughout the military's existence, since before and after the Don't Ask, Don't Tell, and Don't Pursue Policy. This policy would later be shortened to Don't Ask, Don't Tell or DADT.

Other populations who have been segregated, discriminated, harassed, or oppressed during their military service include African American men and women. However, there is one distinct difference when it comes to the LGBT population; it always existed within the military

(Pelts et al., 2015). The military prohibited homosexual behavior since the Revolutionary War, however, it was not until 1942 that gay and lesbians civilians would be specifically excluded from serving in the military (Goldbach & Castro, 2016). LGBT individuals have served in the military before the United States gained its independence and played a pivotal role in America's foundation (Pelts, et al., 2015). In fact, "one of the earliest known gay men in American history, Baron Von Steuben, developed the first military drill book. He is still referenced today in the *U.S. Army Soldier's Blue Book* (2010)" (p. 209). Von Steuben worked closely with General George Washington, focusing on bringing the 13 individual colony armies together, and within weeks all of the units would be training under his direction (Pelts et al., 2015). As the colonies continued to grow, so did the United States Military and its GLB military members. Pelts et al. (2015) highlights the GLB service member's contributions and subsequent legal actions taken by the military against the GLB populations:

> For example, Richard Somers, a ship commander during the First War of Barbary (1801-1805) and his lifelong male companion and fellow service member, Stephen Decatur, were documented as a same-sex couple; a gay Confederate major general, Patrick Ronayne Cleburne; and women who were suspected lesbians who disguised their gender identity to serve. It was during World War I (1914-1918) that the military began to enact laws that punished behaviors…Service members found guilty were treated criminally and imprisoned during the 1920's and 1930s. Moving forward, the military embraced psychiatry's pathology of homosexuality and in preparation for World War II (1939-1945), the military moved quickly to exclude homosexuals from service (p. 210).

The psychiatric professions would contribute significantly to the pathologizing nature of homosexuality and would aid the military in screening out homosexuals, ultimately leading to

discharge from military service and a lifelong label of sexual psychopath (Pelts et al., 2015). The homosexuality diagnosis would eventually be removed from the Diagnostic and Statistical Manual in 1972. However, the United States Military would keep its ban on homosexuals in place, except when they needed to increase the number of service members, with the main rationalization for excluding GLB from service as a "perceived negative effect on unit cohesion and morale" (Pelts et al., 2015).

Today, military service members who identify as GLB, are allowed to serve openly in the military following the repeal of the DADT policy. The policy preventing Transgender populations from enlisting in the military is still under review. The DADT policy was not lifted until 2011 and as a result, presents us with a population whose health care needs are largely unidentified within the military context. Due to the unknown, we must turn to studies of LGBT civilians that indicate there are important health distinctions between LGBT civilians and non-LGBT civilians (Goldbach & Castro, 2016). LGBT civilians have been found to have an increased risk of mental health and physical illnesses. These include, but are not limited to, post-traumatic stress disorder, depression, anxiety, alcohol and drug abuse, and a range of physical illnesses (Goldbach & Castro, 2016).

Johnson, Rosenstein, Buhrke, and Haldeman (2015) identify four general recommendations for mental health professionals, intended to facilitate competent and ethical care of the LGB military population: "Our general recommendations include avoiding harm, developing competence, collaborating with clients regarding sexual-orientation disclosure, and actively consulting with both local and military commanders and DoD policymakers regarding the smooth integration of openly LGB (you might want to be consistent with an acronym – you use GLB above and LGBT below) service members into the U.S. military (p. 111). Goldbach &

Castro (2016) point out that these health care disparities between LGBT military members and their civilian counterparts do not simply go away when the military member is discharged or separated from service. However, research has indicated an increase need for mental health services with LGBT veterans, as concealing their sexual orientation while serving has been associated with higher rates of PTSD and depression (Goldbach & Castro, 2016).

Social workers who provide care for military members, veterans, and their families are encountering a military that has changed, with varying racial and ethnic backgrounds, in addition to those service members now legally serving as LGB (Pelts et al., 2015). Nearly fifty percent of the military is 17-24 years old, a time where their identity is forming and many service members are not fully aware or accepting of their sexual orientation (Pelts et al., 2015). "Add the stress of keeping sexual orientation secretive, likelihood of harassment, historical acts of discharge and the possibility of mental anguish, results in the increased need for well-informed social workers" (Pelts et al., 2015, p. 211). There are many implications for social work practice and education. Training and education for military and civilian mental health providers working with service members, veterans, and their families is imperative. DADT was not repealed until 2011 and any health provider who received training prior to this act being repealed would have received and been offered very limited training and exposure to LGBT military members, leading to questionable knowledge of those military health providers regarding LGBT populations. (Goldbach & Castro, 2016). Effective care of LGB military personnel requires cultural awareness, requiring an "LGB-affirmative and contextually sensitive approach…explore the clients experiences with enacted stigma in the military and any resulting negative feelings" (Johnson, et al., 2015, p. 111)

Compassion Fatigue, Secondary Trauma, and Provider Burnout

Compassion fatigue, secondary trauma, and provider burnout are common terms in the mental health professions. Research targeting military mental health providers in the areas of compassion fatigue, secondary trauma, and burnout is scarce. Secondary trauma has also been referred to as indirect or vicarious trauma. Compassion fatigue in this context refers to the social worker experiencing a state of tension, symptomatology of chronic stress, a strong identification with those who are suffering or have experienced a traumatic event, and reduced empathic abilities. Compassion fatigue can lead to secondary traumatic stress as mental health treatment of military service members and veterans place unique demands on social workers as their clients detail unimaginable and at times incomprehensible war and combat related experiences. In addition, military mental health providers have deployed on numerous occasions to provide care for deployed service members in various locations abroad. Unlike the civilian sector, military mental health providers may not only experience the emotional cost of war in the clinical environment, but also serve in the same austere environments as their patients. "In 2008, the U.S. Army Medical Department directed the duration of deployment of Army physicians and nurses to 6 months instead of the 12 months as evidence was building that health care providers were experiencing increased compassion fatigue as a result of the intense level of care practiced in theater" (Weidlich & Ugarriza, 2015, p. 290).

A combination of compassion fatigue, secondary trauma, and additional occupational stressors may be predictors of burnout among military social workers and mental health providers at large. Provider burnout can be defined by three primary factors, consisting of a pattern of both physical and mental fatigue, negative perceptions and attitude about oneself, and cynicism towards their patients (Browning, Schmitz, Rothacker, Hammer, Webb-Murphy, &

Johnson, 2011). Browning et al. (2011) found that "increased emotional exhaustion was linked with long working hours, whereas personal accomplishment was diminished by having more patients per week" (p. 256-257). The researchers acknowledge that this finding is in fact consistent with previous burnout research as it is to no surprise that increased workloads tend to have an adverse effect on mental health providers emotional states.

Browning et al. (2011) note that their results suggest the higher the social support and number of years worked, the lower the occupational stress and burnout. In addition, they hypothesize that increased administrative and supervisory responsibilities and "less time spent having direct patient contact often results in negative attitudes towards patients over time, as does having too much paperwork" (Browning, et al., p. 258, 2011). The overall results of the Browning et al. (2011) study indicate military mental health provider burnout to be predicted by the size and type of the provider's caseload, amount of hours worked, years of clinical experience, the provider's gender, occupation, and level of social support at their place of employment.

Military service members, inherent in their line of work, are exposed to a variety of traumatic situations. War, and even more specifically, direct combat, presents the service member with situations that may take a toll on the human psyche. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) have witnessed long sustained deployments in high pressure combat situations that have never been seen before.

> For example, improvised explosive devices, roadside bombs, and suicide car bombs have caused over 70% of American Casualties in Iraq and 50% in Afghanistan. Clearly a high number of soldiers have been exposed to and/or witnessed such acts and bring these experiences home. According to the U.S. Department of Veteran Affairs (VA), of the 1

> million veterans who left active duty from Iraq and Afghanistan between 2002 and 2009, 46% received VA services and 48% of those were diagnosed with a mental health problem (Kintzle, Yarvis, Bride, 2013, p. 1310).

The mental health needs of the military population continues to grow and social workers are increasingly called upon to provide competent and adequate care to military members with complex mental and physical health care needs.

The increasing health care demands of returning service members produces increased caseloads for military health care professionals, a rise in traumatic material within the clinical environment, "the amount of time spent in empathic engagement, and the need to emotionally separate professional work demands from one's personal life" (Kintzle, et al., 2013, p. 1310). Kintzle et al. (2013) note the potential protective factors of operating within a military system, as the military culture remains apparent, indicating a strong sense of pride, teamwork, and overall work ethic. However, the military culture may not only be a protective factor for secondary trauma "but also resilience in the face of what is often a difficult but rewarding work" (Kintzle, et al., 2013, p. 1313). Although it has been found that increased level of direct exposure to traumatic material leads to higher reported levels of secondary traumatic stress, research continues to be unclear on how the provider's personal trauma history relates with occupational demands, indirect exposure, and resources influencing secondary traumatic stress (Cieslak, Anderson, Bock, Moore, Peterson, Benight, 2013).

As a result of the large number of service members transitioning from active duty service and entering veteran status, it is vital for social workers to comprehend the unique and often complex veteran health care issues. "Resiliency, coping skills, and burnout/compassion fatigue in military health care providers are important concepts to understand…With a significant number

of Veterans returning to civilian life with physical or psychological injuries as a result of their service in Iraq or Afghanistan, there is a potential for a significant health care crisis in this population of Veterans as the burden on the Veteran's Affair medical system increases" (Weidlich & Ugarizza, 2015, p. 293-294). To prevent or mitigate the risk of developing compassion fatigue, secondary trauma, and provider burnout, it is imperative for social work programs to prepare students who intend to provide care for military populations through education and resiliency trainings. However, as Weidlich & Ugarizza (2015) point out, provider resiliency training must be continually evaluated, reassessed, and revamped, in order to provide the best and most appropriate trainings to handle the often complex and unique demands of military culture.

Part 2: Clinical Interventions & Best Practices when Intervening with Service members, Veterans, & their Families

Chapter 4: Military Trauma and Crisis Intervention

At the core of the social work profession is the person-in-environment perspective. This perspective is a practice guiding principle, referring to the context in which an individual exists (Marquez, 2012). For example, in a military context this means the location of where the service member is stationed, the culture of the installation, military occupation, deployments, and interpersonal relationships. All of these factors affect the way the military member thinks, displays emotions, and ultimately behaves. Military culture and its lifestyle has a significant effect on the military member and their families. If residing on the installation, a military family often has the capability to work, shop, exercise, and enjoy additional recreational activities, all without having to depart the secured military gates surrounding the installation. Many military families receive their healthcare, child care, and form social support networks from within the confines of the installation. Everything is in the name of mission readiness, to support the unique military mission at their respective installation.

> Military values serve as the standards of conduct for military personnel and these rules regulate their lives on a daily basis. Upon entry into service, military values are aggressively imposed on the service members and these norms continue to affect them on and off duty. The military believes that the ubiquitous application of their standards of conduct is necessary because members of the armed forces must be ready at all times to be deployed into combat" (Coll, Weiss, & Yarvis, 2011, p. 489).

Coll et al., (2011) point out that there is an active tension between the highest ideals of the military and the service member's actual experiences, who is a servant to the US political will and interests. Coll et al., (2011) further clarify that the military is indeed a separate society and

"can be employed for less than noble purposes, and the acknowledgement of this reality is often a point of disillusionment for military personnel. Because there is little room for individual autonomy in the military, members of the armed forces must act as a collective and remain dedicated to realizing common objectives" (p. 490). As a result, those military members who question the military system or its mission can be seen as a liability, hence, the military's emphasis on unit cohesion, requiring the sacrifice of the individual good for that of the greater collective good (Coll et al., 2011).

Post-Traumatic Stress Disorder

According to the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (2013), to meet diagnostic criteria for Posttraumatic Stress Disorder it must include a history of exposure to a traumatic event meeting specific symptoms from each of the four symptom clusters: Intrusion, avoidance, negative alterations in cognitions and mood, and alteration in arousal and reactivity. The sixth criterion examines the duration of the disturbance; the seventh assesses whether the event caused clinically significant distress in important areas of functioning (such as social and occupational), and the eighth criterion ensures the disturbance is not attributable to the physiological effects of a substance or medical condition (American Psychiatric Association, 2013).

As a result of our longstanding military operations in Iraq and Afghanistan, posttraumatic stress disorder has been a heavy topic of discussion across mainstream media, academia, scientific and lay communities. However, the discussion has not come without significant debate. "In many traumatic scenarios, it is recognized that much of the reaction is a normal human response to abnormal circumstances…not every warrior gets post-traumatic stress disorder (PTSD), but every warrior is changed by the war zone" (Marquez, 2012, p. 961). However, a

correct estimate of the prevalence of PTSD is vital for projecting the health care needs for service members and our veterans in the future (Hoge & Warner, 2014).

The studies of PTSD prevalence in United States veterans have varied greatly "due in large part to lack of representative samples of the entire population, including those who deployed to war zones as well as the large proportion with service not involving war zone deployment" (Hoge, & Warner, 2014, p. 1439). This data is critically important, as military veterans often report experiencing both military and nonmilitary related trauma, with nonmilitary related trauma prior to the member's deployment being identified as a risk factor for post deployment PTSD (Wisco, Marx, Wolf, Miller, Southwick, & Pietrzak, 2014). Wisco et al (2014) state that prior research has also identified PTSD to be associated with increased risk for psychiatric comorbidity and suicidality. The researchers found consistencies with prior research, with the most frequently experienced trauma among military veterans being the sudden death of a close family or friend, and child/adult sexual abuse being associated with high conditional probabilities of PTSD (Wisco et al., 2014). Veterans reported a lifetime traumatic event approximately 90% of the time, and 34% of those veterans indicated experiencing combat exposure, with sexual assault and level of combat exposure associated with the highest conditional probabilities of PTSD (Wisco et al., 2014).

Overall, the current research supports the conclusion that the prevalence of PTSD in military veterans between the ages of 21-59, including Army service members, "averages approximately 8% after taking into consideration sampling, level of combat exposure, psychometrics, and definitional changes" (Hoge & Warner, 2014, p. 1440). Wisco et al (2014) identified three clinical points for PTSD in United States military veterans:

- The prevalence of PTSD in US veterans is slightly higher compared with the general US adult population, and veterans with PTSD have higher rates of other psychiatric disorders and suicidal behaviors relative to veterans without PTSD.
- Both combat and noncombat related traumas are common in this population and are differentially associated with PTSD risk, suggesting the importance of comprehensive assessment of trauma histories in veterans.
- US veterans with PTSD may benefit from interventions designed to bolster social connectedness and protective psychosocial interventions, such as resilience and community integration (p. 1339).

The increased awareness of the mental health consequences of the war zone has shifted the discourse to more than just an individual problem. There has been recent research examining the familial and intimate relationship problems related to the PTSD of OEF/OIF veterans. Past research has examined veterans who have experienced combat and their familial relationship(s). The research as documented an association between PTSD and familial relationships, in addition to Veterans with PTSD having higher divorce rates than those veterans who have been exposed to combat, however have not been diagnosed with PTSD (Monson, Taft, & Fredman, 2009). PTSD symptoms have also been linked to intimate partner violence, with evidence suggesting that the "PTSD hyperarousal symptom cluster is salient with respect to aggressive behavior" (Monson et al. 2009, p. 708).

In addition to violence and aggression, specific attention has been placed on PTSD and substance abuse problems as the veterans' health administration continues to see OEF/OIF veterans in their 20s and 30s face very unique and at times extremely different challenges from the older Vietnam veteran generation (Bernhardt, 2014). A large majority individuals who have

been diagnosed with PTSD and a co-occurring substance abuse disorder do not seek treatment but rather avoid it entirely; however, approximately 30% of OEF/OIF veterans are estimated to be in substance abuse treatment and concurrently meeting diagnostic criteria for PTSD (Bernhardt, 2009). Stigma was identified as a primary barrier to seeking care (Bernhardt, 2009), which in the case of the military this stigma "stems from cultural beliefs and attitudes about mental health that influence negative beliefs psychologically distressed service members have about themselves…military culture unintentionally perpetuates a mental health stigma through military leaders as well as other aspects of the health care and military environment" (Gibbons, Migliore, Convoy, Greiner, & DeLeon, 2014, p. 365). Bernhardt (2009) stated that there is evidence suggesting individuals who seek treatment for both PTSD and substance abuse treatments often have poorer prognosis' than those individuals who have only been diagnosed with one or the other.

A military member who experiences PTSD is at increased risk for employment, educational, and interpersonal relationship difficulties. As a result there are significant social, political, and economic implications, and therefore an absolute necessity that significant time is allocated to assessing, treating, and preventing the severity of PTSD in military members. The collective literature has informed us of the significance regarding the current and higher lifetime prevalence of PTSD, this will be felt long into the future and has substantial implications for veteran's health care preparation, development, and planning to ensure delivery of competent evidence based services for our nation's veterans (Hoge & Warner, 2014).

Military Sexual Trauma

Military Sexual Trauma, or MST, is a term coined by Veterans Affairs (VA) referring to the "experiences of sexual assault or repeated, threatening sexual harassment that a Veteran experienced during his or her military service" (Department of Veteran Affairs, 2015). Furthermore, MST, includes any type of sexual activity where a military service member is involved in an act against his or her will. (Department of Veteran Affairs, 2015). There are a range of experiences that fall under the MST category; such as, feeling pressured or forced into sexual activities, experiencing unwanted touching or grabbing, and receiving threatening or offensive remarks about one's body of a sexual nature (Department of Veteran Affairs, 2015). The Department of Veterans Affairs (2015) considers MST to be an experience that occurs while the individual service member was on active duty service, active duty for training, or inactive duty for training.

Military sexual assault is a preventable occupational hazard that is associated with "broad and pervasive health consequences among U.S. Veterans" (Barth, Kimerling, Pavao, McCutcheon, Batten, Dursa, Peterson, & Schneiderman, 2016, p.77). Barth et al (2016) state that 6.1% of women and 1.2% of men had reported a sexual assault related incidence, while 23% of women and 4% of men reported a sexual harassment incidence in 2012. The VA implemented a MST universal screening program as part of their standard clinical practice in 2002, where a reminder is placed in every veteran's electronic medical record (Barth et al, 2016). The screening data has indicated that 20.5% of women veterans and 0.8% of men veterans who have received care in the VA system and recently returned from OEF/OIF deployments, reported MST when screened by a VA provider (Barth et al, 2016). The Department of VA (2015) state that the VA's MST national screening program has revealed that estimates of 1 in 4 women and 1 in 100 men

have answered "yes" to experiencing MST when they were screened by the VA; however, this data only refers to those Veterans who have elected to receive healthcare in the VA system.

The Department of Defense (DOD) data indicated a 58% increase in reporting of sexual assaults from 2012-2014, totaling to 6, 131 unrestricted and restricted reports of sexual assault in 2014 (Johnson, Robinett, Smith, & Cardin, 2015). The restricted reporting of sexual assaults means the report is confidential and does not require an official criminal investigation. The restricted reporting option was established to increase military service member's willingness to seek assistance, treatment, and additional resources (Johnson, et al., 2015). However, Johnson et al (2015) state that although the increase in reporting has been identified, the DoD data suggests that most survivors of MST do not report, estimating nearly 18,900 military service members were victims of sexual assault in the year 2014.

As the reported sexual assault numbers increase, so do the questions regarding prevention. "The occurrence of this violence goes directly against the values, honor codes, and laws of the U.S. military and instead harms those who have sworn to serve and protect their country" (Turchik & Wilson, 2010, p. 269). There is not one factor linking sexual violence to the military; however, a number of factors that must be considered. Turchik & Wilson (2010) point out several of the factors that may contribute to sexual violence in the military, however, acknowledge that additional research and empirical evidence is needed. The military is an all-volunteer force, consisting of different demographic compositions, fewer women, younger adults, fewer individuals with college degrees, and several studies have found high rates of prior childhood and adolescent sexual abuse before joining the military (Turchik & Wilson, 2010). The previous research has documented sexual victimization as being more prevalent amongst

younger adults than older adults, with estimates approximately 83-87% of victims and 40-68% of offenders between the ages of 17-24 (Turchik & Wilson, 2010). In addition;

> The culture of violence that characterizes the military may contribute to the increased risk for sexual victimization within the organization…the male-dominated environment of the military has traditionally not been very inviting or prepared to handle the needs of women…and considerable literature has developed linking men's negative attitude towards women, acceptance of violence, and tolerant attitudes towards rape and sexual harassment to male perpetration of sexual assault" (Turchik & Wilson, 2010, p. 271).

Although the prevalence rates of MST vary extensively, there are significant health implications associated with MST.

Military sexual trauma is not considered a diagnosis but an experience, resulting in various forms of treatments needed (Department of VA, 2015). The DOD and VA has taken considerable steps forward in recent years to provide appropriate treatment options for those who have experienced military sexual assault. The current treatment models for MST services involve establishing safety and stabilization, healthy coping skills, group treatment specifically for women, psychoeducation for those who do not meet diagnostic criteria for PTSD, individual skills training for men, and group work for men (Johnson et al., 2015). The second stage of treatment is provided through empirically supported trauma focused treatments; such as, trauma focused CBT, exposure therapies, cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) (Johnson, et al., 2015). PTSD has been commonly linked with MST, however, it is not the only diagnosis that can result from experiencing MST, with VA Medical record data linking "the diagnosis most frequently associated with MST among users of VA health care are depression and other mood disorder, and substance use disorders"

(Department of Veteran Affairs, 2015). The VA and DOD continues to ensure our nations veterans have access to available resources and assistance they may need in regards to military sexual trauma. The VA has established a designated MST coordinator, universal MST screening protocols, all MST treatment is provided at no cost, veterans do not need to have a service connected disability, MST services are available at every VA medical center with appropriately credentialed and knowledgeable providers in regards to MST, programs are offered on an outpatient and in residence basis, and some facilities offer gender specific treatment programs (Department of Veteran Affairs, 2015).

The Department of Defense has implemented an office that is responsible for overseeing the education, treatment, response, and additional services for those service members who have experienced sexual assault. "The most significant change was the permanent implementation of the DoD Sexual Assault Prevention and Response Office (SAPRO) in 2005…who is responsible for the entire DoD, including four of the five branches of the military…serving as a single point of accountability for sexual violence (Turchik & Wilson, 2010, p. 273). The SAPRO program provides education, training, prevention, and treatment resources for all sexual assault survivors. This streamlined single point of contact serves as the primary consultant regarding sexual assault and takes both restricted and unrestricted reporting options. The SAPRO's confidential reporting option for sexual assault survivors allows military service members to receive proper medical care and counseling services without having to notify the members command or law enforcement agencies (Turchik & Wilson, 2010). However, it is important to note that the restricted reporting options can only be initiated by medical or mental health providers, SAPRO victim advocates, sexual assault response coordinators (SARC), or chaplains. The military member's commander or any member of law enforcement (both on and off the installation) are required to report the

sexual assault to the appropriate authorities, triggering a criminal investigation, which could potentially decrease the likelihood of reporting (Turchik & Wilson, 2010).

Suicide Prevention

This section will focus on military suicide rates, risk, and prevention efforts. The Department of Veterans Affairs (2015) note that the rate of suicide was greatest in the first three years after being discharged from service for veterans who served during Iraq and Afghanistan between 2001-2007. Prior to the wars in Iraq and Afghanistan, suicide rates among active duty service members and veterans had been 20-30% lower than the United States general population (Kang, Bullma, Smolenski, Skopp, Gahm, & Reger, 2014). The wars in Iraq and Afghanistan are vastly different from previous wars; including repeated sustained deployments, different style of warfare, an older all volunteer-force with increased likelihood of having families, and more women serving than ever before (Kang et al., 2014). According to the Department of Veteran Affairs (2015), deployed and non-deployed military veterans had a higher risk of suicide compared to the general United States population, with deployed veterans having an even lower risk of suicide compared to non-deployed veterans. In fact, Kang et al (2014) note that those military service members electing to remain in service post deployment are believed to be healthier than those military members who were discharged from service.

The Department of Veterans Affairs (2015) reported on the findings from a study by Kang et al (2014) that examined the vital status of 1.3 million veterans who were on active duty during the Iraq and Afghanistan Wars between 2001-2007 (followed through the end of 2009) and reported the following:

- Deployed veterans had a 41% higher suicide risk compared to the general U.S. population and non-deployed veterans had a 61% higher suicide risk compared to the general U.S. population.
- Of the 317, 581 total veterans who had deployed, 21.3% were deaths due to suicide and of the 964, 493 total veterans who did not deploy, 19.7% were deaths due to suicide.
- In addition, female veteran suicide rates were about a third of the male veteran suicide rate. Regardless of the veteran's deployment status, the highest suicide risk was amongst young, white, male, unmarried, enlisted Army/Marine veterans.

More recently, data has estimated US veteran's suicide rates at 25.1 deaths per 100,000, nearly tripling that of United States civilian population, translating to approximately 22 Veteran suicides a day (Pease, Forster, Davidson, Holliman, Genco, & Brenner, 2016).

Understanding risk factors and warnings associated with suicide involves "making informed decisions regarding suicide risk assessment practices…whereas risk factors are epidemiologically based variables associated with increased risk of suicide over a lifetime, warning signs or symptoms that indicate risk of suicide in the immediate future" (Pease et al., 2016). There are non-modifiable and potentially modifiable risk factors; such as gender and race versus substance use disorders and poor problem solving (Pease et al., 2016). Although there has been increased attention on suicide prevention, to include universal health care access and mandatory trainings, "suicide has become one of the leading causes of death in the US military in recent years" (LeardMann, Powell, Smith, Bell, Smith, Boyko, Hooper, Gackstetter, Ghamsary, & Hoge, 2013, p. 497). LeardMann et al (2013) acknowledge that despite increased attention and suicide prevention efforts, it continues to be a difficult topic to study; however, military and civilian leaders continue to prioritize the need for understanding circumstances and

risk factors leading to suicide in military populations. LeardMann et al (2015) reiterate the notion that the findings from their study are not consistent with assumptions that suicide risk is directly related with deployment and combat experience. They note that the study results indicate consistency with civilian population risk factors; such as, male sex, mental health disorders, and "the increased rate of suicide in the military may largely be a product of an increased prevalence of mental disorders in this population, possibly resulting from indirect cumulative occupational stresses across both deployed and the home-station environments over years of war" (LeardMann, et al., 2013, p. 502). The most important finding from the LeardMann et al (2013) study on risk factors associated with suicide in current and former US military personnel were mental health issues and alcohol related problems as being significantly associated with an increased risk for suicide.

Military populations are not immune from the same biopsychosocial risk factors their civilian counterparts experience; however, do have distinct set of military relevant risk and protective factors (Martin, Ghahramanlou-Holloway, & Tucciarone, 2009). "Considering the synergistic power of converging risk factors, military individuals present with unique constellations that can result in increased risk for suicide behavior" (Martin, et al., 2009, p. 106). These unique risk factors include combat exposure and deployments presenting an increased risk for mental health disorders, failing intimate relationships, occupational dissatisfaction, easy access to firearms, legal stressors, and substance use disorders that may be particularly relevant to military populations. (Martin et al., 2009). In addition, military members younger in age, a history of legal problems, and poor performance evaluations were found to be key differentiators in those who attempted suicide and those who did not (Martin et al, 2009).

For mental health providers providing assessment, treatment, and prevention services to military populations, Martin et al (2009) emphasize the role stigma plays in preventing military members and veterans from seeking the appropriate help and note the following:

> We emphasize the clinical power of empathy: Individuals who think and plan for suicide often experience varying degrees of hopelessness. Exposure to even one mental health professional who can demonstrate compassion, understanding, empathy, hope for the future, and a determination to go the extra mile may be instrumental in saving the life of an active duty military service, member veteran, or family member" (p. 109).

Captain Gina Blocker and Major Joel Miller of the United States Army wrote an editorial in 2013 in the Journal of Military Medicine on the *Unintended Consequences: Stigma and Suicide Prevention Efforts.* They highlighted the significant attention and large amount of resources that have been directed towards educating, screening, and accessing care for at risk military members; however, "are concerned that in this environment of heightened visibility and accountability, unit and provider responses may be paradoxically increasing stigma and presenting new barriers to care" (Blocker & Miller, 2013, p. 473). They further illustrate how the new prevention efforts have shifted responsibility from the member and placed it onto the unit and the mental health provider; instead of promoting self-care, the model focuses heavily on the members command and mental health provider screening for suicide and on the instant escort of any military member that may be at-risk for suicide (Blocker & Miller, 2013). Military mental health providers often encounter service members who have been escorted by their commander for an immediate and mandatory mental health evaluation, and command leadership are often unwilling to allow military members "with even the suggestion of an abnormal mood to maintain their autonomy without first being cleared by the ED or behavioral health clinic" (Blocker &

miller, 2013, p. 473). Blocker & Miller (2013) argue that command leadership should promote an environment in which military members feel comfortable and are encouraged to seek care, while mental health providers should make every effort to respect the service members autonomy when an immediate threat does not exist, and while even in the best of circumstances command must recognize "not every suicide can be predicted or prevented, and focus should shift away from punitive responses to suicide for the providers and unit leadership involved" (p. 473). Military service members on active duty who attempt suicide may continue to serve, be administratively separated, or receive a medical evaluation board. The variability stems from the service members mental health history, "lethality of the attempt, and the military and political circumstances of the time" (Ritchie, 2003 p. 177).

Resilience

How do we define resilience? The term resilience has been used in many different ways; however, Fikretoglu and McCreary (2012) embraced a challenging task of defining resilience and through extensive research on the historical development of the term and reviewing a number of definitions, they define resilience "as the demonstration of positive adaptation in the face of significant diversity (Britt, Sinclair, & McFadden, 2013, p. 6). McGarry, Walklate, and Mythen (2015) point out that the term resilience and its usage has increased across a range of disciplines and explored what being resilient may mean for service members, specifically examining the "interaction between their personal masculine characteristics, the structural environment within which they operate, and the civilian life they return to" (p. 352). The term resilience has been utilized almost exclusively in reference to the United States Armed Forces and largely from a psychological perspective, in which the individual capacity for resilience is often seen as a personality trait (McGarry, Walklate, & Mythen, 2015). One of the more

important concerns regarding military resilience is whether or not resilience is defined as a singular trait, a collection of personality traits, or an outcome of traits (Sinclair et al. 2013).

Illustration 4

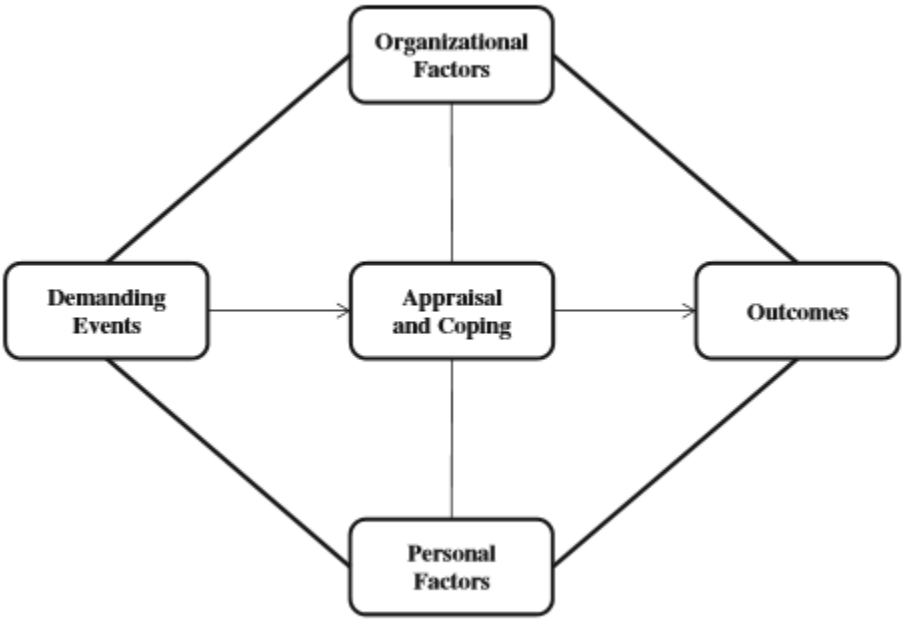

Figure 1.1. A framework for the study of military resilience.

(Britt, Sinclair, & McFadden, 2012, p. 10).

The framework for the study of military resilience (Illustration 4) is an organizing framework used by Britt, Sinclair, & McFadden (2012), is based on the soldier adaptation model (Bliese & Castro, 2003), and is a "representation of resilience –related processes where soldiers' appraisal and coping responses influence the outcomes the soldiers experience from potentially demanding events (e.g., combat). This process is influenced both by the individual characteristics

of the soldiers and by characteristics of their organization, including their particular units and the broader military environment" (pp. 9-10). Britt, Sinclair, & McFadden (2012) acknowledge that leadership is a critical issue in the armed forces; however, literature on the relationship between military leadership and resilience is scarce. They refer to the early 21st century as the "resilience renaissance of sorts, as, largely in response to conflict in the Middle East, the U.S. military and nations contributing personnel to Operations Enduring Freedom and Iraqi Freedom have begun to examine training programs to promote and maintain resilience" (Britt, Sinclair, & McFadden, p. 13).

What place does resilience have in the military? How should the military apply the personality based resilience concept? Sinclair et al. (2013) point out that it is more important than ever to choose individuals with resilient personalities "as well as to afford less resilient people the opportunity to screen themselves out of extremely demanding occupations…it follows that organizations also should provide continual training to develop and maintain resilience" (p. 38).

Chapter 5: Evidence Based Practice & Approaches with Service Members

A Critical Look: The Medicalized Model of Military Mental Health- Evidence Based or Cultural Based Practice?

The medicalized model of military mental health practice provides us with many competing interests. Does the medicalized model benefit the system, the client, or both? What are the political, economic, and social implications for both the military health system and individual service member? Clinical training is essential, needing to "emphasize that beyond any biological basis, medicalized conditions have a cultural, historical, and political trajectory in their conception and perception" (Behrouzan, 2015, p. 53).

The military social worker is portrayed as a medical officer within the military health system. One of the primary responsibilities of a military social worker is to assess, evaluate, and determine whether a military service member is fit for duty. In the 1960's, mental health facilities on military installations were called mental hygiene clinics. The military mental health field still operates from a similar framework, believing that "social problems can be resolved by improving the mental functioning of individuals" (Becker, 2014, p. 31). For instance, if a military member is being treated for a chronic adjustment disorder (adjustment problems lasting for more than 6 months), he/she must be considered for a medical evaluation board and potential discharge from military service. This locates the problem in the individual client's inability to adjust to the system, failing to recognize potential pitfalls within the system. Similarly, Becker (2014) highlights the mental hygiene legacy, and how the "message of adaptation and adjustment has helped shape the fields of psychiatry, psychology, and social work" (p. 31).

The military social worker is required to work directly for the commanding officer. Fitness for duty evaluations involve the social worker and military member engaging in a clinical

encounter. Within the context of that clinical encounter, the social worker must maintain allegiance to the military system, probing for any duty-limiting factors that may impact a service member's ability to perform the job. A diagnosis from the DSM-5 has far-reaching effects on service members. The mere documentation of a PTSD diagnosis has severe social, economic, occupational, and political implications.

Within the military mental health system, the mental health provider must operate under distinct evidence based practice (EBP) clinical guidelines and Department of Defense instructions. The mental health provider is provided with a checklist-like model for record keeping, entailing templated notes that must indicate the evidence based practice modality that was employed within the therapeutic session. Olson (2014) points out how an overemphasis on evidence-based practice models "may reduce multidimensional, contextual issues to a narrow psychological perspective and divert attention from the wide-ranging effects of war on families, communities, and society as a whole" (p. 184).

Allan Young, author of *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder,* traces the genealogy of the Post Traumatic Stress Disorder (PTSD) diagnosis and provides us with a critique of PTSD, including detailed accounts of treatment for Vietnam Veterans with PTSD. Young examines the construction of PTSD as a cultural product. Scandlyn (2012) examines Allan Young's work on the Harmony of Illusions, pointing out that Young begins with the statement that PTSD is unquestionably real. "It is not an idea in people's minds, but part of our social and material world that affects our institutions and our bodies through diagnosis, treatment and compensation for suffering" (Scandlyn, 2012, p. 130). Young looks back at PTSD from the early accounts of railway spine in the mid nineteenth century to its

incorporation into the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM) III in 1980 (Scandlyn, 2012).

Young acknowledges that the suffering from traumatic experiences has existed since the beginning of time, however, "PTSD could not exist until scientists invented the concept of traumatic memory" (Scandlyn, 2012, p. 130). Young pays close attention to the creation of the PTSD diagnosis as a response to an interest group of Vietnam Veterans and their political supporters (Jenkins, 1997). Jenkins (1997) notes that PTSD also significantly benefited the legal profession, "whose access to media and politicians is generally far superior to that of medical experts. With the psychiatrists and medical theorists, these groups contributed to the process by which the scientific "fact" of PTSD was determined and promulgated" (p. 1267). The concept of the traumatic event introduced PTSD as the first psychiatric diagnosis to have an external cause, and the stored traumatic event results in traumatic memory (Scandlyn, 2012).

> The event, stored as a traumatic memory, can evoke distress when recalled, thus creating characteristic symptoms whose physiological effects can, in theory, be measured. Through this process of scientific reasoning and technology, Young argues, PTSD becomes a techno phenomenon with its own internal logic, a legitimate, medical diagnosis for which veterans could receive compensation and treatment (Scandlyn, 2012, p.130).

Behrouzan (2015) points out how PTSD can serve as "a channel through which to interpret and articulate emotions and memories that are indescribable" (p. 48). Those service members deemed unfit or unable to adjust to the military system as a result of a mental health disorder are referred to a medical evaluation board. This process can assist the client in the meaning-making process, provide them a voice, disability compensation, and free health care for the duration of

his/her life. Behrouzan (2015) describes medicalization as a cultural resource, specifically the diagnosis of PTSD, historicizing the experience and "creating a generational voice that demands justice and accountability" (p. 48).

As Young focused so eloquently on the development and construction of the PTSD diagnosis, contributing greatly to understanding the history and culture of science, we must also critically examine empirically based research and expert power that supports the evidence based practices treating the psychiatric disorder(s). In a 2008 journal article in the European Journal of Psychotherapy and Counselling, Guilfoyle examined Cognitive Behavioral Therapy's (CBT) integration into societal networks of power, and the already existing cultural and institutional power arrangements, leading to the eventual rise as the therapy of choice. Similarly to Young's work, Guilfoyle (2008) examines how CBT fits into the contemporary power arrangements of the legal, educational, psychiatric, psychological, and political institutions. He also noted that the increase in power and dominance that CBT has gained in the therapeutic world, makes it increasingly more difficult to challenge on a scientific, ethical, or political level.

The rapid rise of CBTs dominance in the therapeutic world is worth critiquing and developing a further understanding of how the rapid rise came to be. Guilfoyle (2008) focused on ethics and argues that "CBT focuses on problems rather than the people, and how the nuanced ethical questions concerning the subtleties of power operations and the constructive power of language can be appropriately addressed" (p. 198). He poses the notion that clinical categories can have self-fulfilling effects, leading to clinical encounters resulting in more of a monologue than dialogue, ignoring the social, cultural, and political forces at work (Guilfoyle, 2008). The military mental health system is predicated on a brief treatment model, with a return to work agenda. The CBT model seems to fit the systems agenda, however, attention must be focused on

how and why a therapeutic modality becomes to be considered the most scientific therapy and as a result a consensus amongst the profession.

> Guilfoyle (2008) further illuminates this idea and stated: Under the influence of such consensus-and the positive valuation placed on consensus as opposed to difference- the critical therapist starts to doubt his or her own ideas, as the impression is created that right thinking practitioners recognize the importance of having therapeutic work monitored and legislated, of evidence based practice, of meeting economic needs, insurance company demands, and psychiatric and forensic requirements of clear diagnoses, categorical interventions and unequivocal recommendations (pp. 200-201).

Guilfoyle (2009) goes on to explain how the aforementioned list of demands results in a "therapeutic hegemony" (p. 201) setting in, as the therapy world is slowly overtaken by a limited selection of evidence based approaches.

Continuing with the idea that PTSD and trauma in general as grounded in cultural and social contexts, it is important to delve deeper in understanding military culture and its profound influence on how we have come to conceptualize trauma. Culture is more than just race, ethnicity, and family lineage, it is "through and within a cultural frame that individuals construct their realities, meanings, and identities" (Nicolas, Wheatley, & Guillaume, 2015, p. 37). The earliest theories of trauma and PTSD were largely based on combat stemming from military service. "In many cultures, the community ordinarily provides the secure base for an individual's adaptive responses to stress, trauma, and loss" (Nicolas et al., 2015, p. 38). However, the support will vary within each culture. This variation takes place as a result of preconceived notions, severity of disruption within the culture, values, and norms. Through the mental health professions practice, research, and providing the media with the professions psychological

jargon, PTSD has become nearly synonymous with combat. Instead of the traumatic reaction being examined as a form of conditioned survival response, the symptomatology is often categorized and clinically justified into a psychiatric diagnosis requiring scientific evidence based treatment and often psychiatric medications. It is critically important to develop awareness and competence when working cross culturally, whether globally, or directly within the United States. Nicolas et al. (2015) question the westernized application of trauma, stating that "efforts should be made to reduce the promotion of a narrative of victimization and instead focus on recovery and well-being promotion within a community-based context" (p. 42). This shift in focus and increased understanding could assist in decreasing the pathologizing nature of the PTSD diagnosis that perpetuates stigma, barriers to care, and institutional control.

Prolonged Exposure Therapy

Prolonged exposure therapy (PE) is an evidence based, manualized treatment protocol, that was specifically developed for posttraumatic stress disorder and is rooted in a "long tradition of exposure therapy for anxiety disorders, and in the conceptualization of these disorders and their treatment within emotional processing theory (EPT)" (Foa, 2011, p. 1043). Furthermore, research has shown prolonged exposure therapy to be one of the most effective treatment protocols for PTSD, leading to the Department of Veteran Affairs development of a national PE training program and designation as a first line intervention program (Department of Veteran Affairs, 2015).

Foa, Hembree, & Rothbaum (2007) "emphasize that emotional processing is the mechanism underlying successful reduction of PTSD symptoms" (p.1). Prolonged exposure therapy has four unique parts: education, breathing, real world practice, and talking through the trauma (Department of Veteran Affairs, 2015). During session 1 of treatment, the client is

presented with the overall rationale of the treatment protocol and provided psychoeducation (Foa, Hembree, & Rothbaum). The psychoeducation component involves the introduction of how avoiding the trauma reminders "serves to maintain PTSD symptoms and trauma-related distress and the PE directly counteracts such avoidance" (Foa, Hembree, & Rothbaum, 2007, p.2). Psychoeducation continues through session 2 and begins to facilitate a discussion between the therapist and client that involves talking about the common reactions to trauma, aiming to elicit and discuss the client's reactions to their own trauma experiences (Foa, Hembree, & Rothbaum, 2007). Session 1 also includes the skill of breathing retraining, intended to help the client control their breathing to manage the distress and decrease anxiety and fear that may be impacting the client in their day-to-day functioning (Department of Veteran Affairs, 2015).

Foa, Hembree, & Rothbaum (2007) highlight in their Prolonged Exposure Therapy for PTSD therapist guide that the breathing component of PE is not essential to both the process and overall outcomes of PE treatment; being that breathing exercises may actually be a hindrance to treatment, allowing the client to avoid instead of directly experiencing their ability to cope with their trauma related memories.

The heart and soul of PE treatment involves real world practice or otherwise called in vivo exposure, and talking through their trauma which is referred to as imaginal exposure. In vivo exposure is introduced during session 2 of PE treatment, and practices approaching safe situations that the client may have been avoiding because the situations, activities, places, or objects were related to their trauma experiences (Foa, Hembree, & Rothbaum (2007). The client will begin to understand that their trauma related memories and situations are not in fact dangerous and continuing to confront these memories will ultimately decrease their distress. PE protocol is designed in a way that allows the client to complete their in vivo exercises primarily

as assigned homework, on their own and outside of the therapeutic encounter. Session 3 involves imaginal exposure, where the client talks through their trauma, intended to assist the client in regaining control over their own thoughts and feelings about their trauma related memories. The primary aim of in vivo and imaginal exposure "is to enhance emotional processing of traumatic events by helping them face the trauma memories and the situations that are associated with them…Ultimately the treatment helps PTSD sufferers reclaim their lives from the fear and avoidance that restrict their existence and render them dysfunctional" (Foa, Hembree, & Rothbaum, 2007, p. 3). Prolonged Exposure Therapy typically involves 8-15 sessions of individualized treatment with a trained therapist, with most sessions lasting 90 minutes,

Cognitive Processing Therapy

Cognitive Processing Therapy or CPT is has also been rolled out as a first line intervention for PTSD by both the Department of Veteran Affairs and Department of Defense. CPT is an evidence based, manualized treatment approach focused on PTSD symptom reduction. CPT is a 12 session treatment model that focuses on addressing PTSD themes; such as, safety, control, and trust (Dahl, 2015). CPT was originally developed for use with sexual abuse victims, and with its proven efficacy, has been used across multiple populations, to include military service members and veterans (Dahl, 2015). "CPT is an adapted treatment manual using social-cognitive theory approaches in a manualized treatment format…major concepts in CPT include a variety of social cognitive theory and cognitive behavioral therapy tenets, including accommodation, assimilation, overaccommodation, and PTSD" (Dahl, 2015, p. 180).

The Department of Veteran Affairs National Center for PTSD (2015) identify the four main parts of CPT as: Learning about your PTSD symptoms, becoming aware of thoughts and feelings, learning skills, and understanding changes in beliefs. The initial component of CPT

focuses on education that are specific to that clients PTSD symptoms and why CPT is the right evidence based treatment for that client. The second part of treatment that involves becoming aware of ones thoughts and feelings, focuses on stuck points and pays particular attention to thoughts about the trauma and how it affects the clients daily functioning. The client can complete this process verbally with their therapist or written narratives about their trauma. As the client develops awareness in regards to their thoughts and feelings, they will learn skills to challenge their thoughts with the help of their therapist and the use of written worksheets. The final component is understanding ones changes in beliefs after experiencing trauma, and finding a better balance between the pre and post trauma belief systems (Department of Veteran Affairs, 2015). Throughout CPT treatment there are several techniques utilized according to the CPT manual. These techniques include the trauma impact statement, Socratic questioning, stuck points, identification of thoughts and feelings, and specific topic sessions (Dahl, 2015).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) focus' on working with the client in the present, combining behavioral and cognitive therapies, generally in a directive manner that challenges the client's problematic thoughts in an effort to change the behaviors related to those problematic thoughts (Rice, 2015). CBT is historically rooted in the work done by Albert Ellis through rational emotive therapy in the mid-1950's, prior to Aaron Beck developing a similar approach called cognitive therapy in the 1960's (Rice, 2015). CBT has been influenced by many new theories. "CBT comes in many shapes and forms and has become a dominant force in psychotherapy in much of the world. This is largely due to the increased focus on evidence based practice and related demands for accountability in the delivery of mental health services" (Rice, 2015, p. 195).

Cognitive behavioral therapy has a number of distinct components that fits closely with the occupational demands of the military. CBT is intended to be short term, directive, structured and collaborative (Rudd, 2012). Brief cognitive behavioral therapy (BCBT) is a compact and time limited psychotherapy that has "considerable potential as an adjunctive treatment for major depression and post-traumatic stress disorder" (Rudd, 2012, p. 593). CBT's major concepts include behavioral and cognitive concepts. The cognitive concepts include the following: full consciousness, automatic thoughts, and schema (Rice, 2015). The behavioral concepts highlight that it is normal to avoid things that are painful; however, avoidance can become problematic if it becomes the primary modality for dealing with difficult circumstances or life situations (Rice, 2015). CBT psychotherapists utilize a variety of techniques to assist clients in challenging and changing their cognitions and behaviors. The cognitive techniques include use of socratic questioning, cognitive restructuring, reality testing, guided imagery, imagery based exposure, and cognitive rehearsal (Rice, 2015). While the behavioral techniques may include activity and pleasant event scheduling, graded task assignments, diaphragmatic breathing homework, modeling, and writing in a journal (Rice, 2015).

Motivational Interviewing

Motivational interviewing or MI is client centered, collaborative, and directive therapeutic style that seeks to elicit behavior change by assisting the client(s) explore and resolve ambivalence. Motivational Interviewing explores the clients own reasons for change, while the therapist seeks to evoke "change talk-expressions of the client's desire, ability, reasons, and needs for change-and responds with reflective listening" (Hettema, Steele, & Miller, 2005, p. 92). Motivational Interviewing is typically brief and can be conducted in just a few sessions, and is intended for the counselor or therapist to do more listening and less telling. MI is learned

overtime and is compatible with a variety of other approaches, proving most effective when there is a clear desire for change (Hettema, Steele, & Miller, 2005). MI is not intended to coerce the client into changing; however, foster a conversation between the client and therapist that is empathic and meets the client where they are. The tenants of MI fall closely in line with social work values and ethics. In 2010, Cowell et al. examined the costs of using motivational interviewing for problem drinking in the U.S. Air Force. Cowell et al.(2010) acknowledged that MI was one of the most successful brief interventions, has proven effective in younger samples, and with such a large proportion of young personnel making up military populations, it can be a particularly productive population to implement motivational interviewing.

Chapter 6: Trauma Informed Care for Military Populations

The focus of this chapter will examine an active duty mental health clinic on a secured military installation, staffed by uniform and non-uniformed mental health providers, through a trauma informed system lens. The chapter will critically evaluate and challenge how trauma informed care can be accurately implemented within a system that is fundamentally based on promoting violence. Violence is often synonymous within the military context. The military involves deterrence, assurance, and if necessary, killing another human being through hand-to-hand combat or human developed weaponry. The intention of the military is to keep the nation safe and secure--anytime, anywhere. This presents the mental health provider with a rather paradoxical relationship. The ethical code for any mental health discipline involves the concept of 'do no harm.' This leads to the following questions: What is the mental health professions role in the military? What is the military's role in the mental health profession, and how is mental health utilized as an asset to support the broader mission? As non-combatants, how can mental health professionals, and even more specifically active duty uniformed mental health providers, guarantee non-violence as a norm? Finally, how does the mental health system build an environment that leads military service members, veterans, and their families towards a safe, stable, and recovery oriented environment?

Analyzing the System

Prior to entering their first duty station, the active duty mental health professional must complete commissioned officer training. Training consists of an indoctrination course that is focused on military belief systems, values, culture, and medical readiness in the name of the military mission. This military training offers the newly minted commissioned officer(s) a firsthand glimpse at the role of the uniformed medical officer. The military mission is

paramount, coming before one's own life, and in the face of unthinkable adversity, is asked to lay down one's life for the betterment of their country. Patriotism, pride, sacrifice, toughness, and resilience are common phrases utilized in military settings. Unlike our current individualized societal norms, the military is a collective unit, and in order to succeed as a member of the armed forces, you must abide by the orders of your superiors and be fully devoted to the military mission.

This has the ability to increase organizational risk factors for military mental health providers. Providers are often on call 24/7 providing direct command consultation or client care, leading to little or no respite. As a result of additional duties both within the confines of your profession as a mental health provider and also a military officer, this increases chances of higher caseloads and role ambiguity. Your primary role as an active duty mental health provider is to work for the commander, to ultimately determine a member's fitness for duty. Military mental health providers complete security clearance evaluations, command directed fitness for duty evaluations, alcohol and drug assessments, and intimate partner violence maltreatment referrals. Through this process, the mental health professional is tasked with assessment, treatment, and ultimately providing medical recommendations to the client's commander. This recommendation often holds a significant amount of weight in the life of a service member and their family. According to the respective branches regulations and instructions, a mental health diagnosis can determine the service member's future, a potential medical or administrative discharge. This creates ethical dilemmas and tension within the therapeutic dyad. A decision that may benefit the military, may have long term effects on the client, and vice versa. This tension is inherent in military mental health practice, effecting the client and the clinician on a continuous basis. The military requires manpower, and manpower equals productivity. If the military commander does

not have the manpower to complete the mission then they must discharge a member from their unit to make way for another human asset. This is where mental health may serve as an asset to the commander, and furthermore, to the Armed Forces.

The military mental health provider is not only tasked with serving state side; however, also functions in many capacities abroad and on military operational deployments. This introduces the notion of shared trauma—between the client and the clinician. Here, presents a dilemma that is rarely, if at all, observed in civilian mental health practice. The individuals treating the population, are indeed members of that population, working as a collective unit to sacrifice their own lives for the well-being of the group. The trauma may not only be shared verbally in session, but also through lived combat experiences. For example, consistent and persistent mortar attacks on their deployed installation is an experience that both the clinician and client will experience. Also, trainings and lengthy deployments away from family is often a similar shared characteristic, potentially increasing chronic and prolonged stress on both the mental health professional and the service member. The ethical boundaries may become blurred in what is known as the fog of war, when one's life is on the line, human instincts grounded in military training may very well take over. Bloom (1996), touches on this concept when discussing the social group reenactment:

> "Even today, military training is highly repetitive and ritualized, decreasing the likelihood of individual, diversive action. The ritual behavior, through the induction of altered states and the group modulation of affect, also served to buffer the entire group from overwhelming states of arousal in the face of danger. To the extent that the ritual behavior appeared to give control over dangerous ecological events, the group obtained a sense of control thus counteracting individual and group helplessness (p. 177)

This repetition of military training allows the group to have an illusion that members of the Armed Forces can control the forces of natural and human evil (Bloom, 1996). This illusionary sense of control may be seen as an effective coping mechanism in times of war, especially for the young men and women who have had minimal time for soul searching, while their brains are still developing. Acknowledging this sense of illusionary control would indeed go further than focusing on presenting symptoms, such as insomnia as a result of 24/7 mission requirements in a combat zone. Here, the service member must continue to maintain his allegiance to the mission and find a temporary solution, such as being prescribed Ambien. This presents a short term solution for a potential longer term problem; however, it is imperative that we reinforce the individuals sacrifice for the greater good. There is little to no time focusing on sleep hygiene techniques when you must be on guard 24/7, protecting not only your own life, but the life of the entire unit. If the mental health provider were to focus on this notion of illusionary control, it would be a fine balance of identifying issues within the system and be counterproductive to the mission at hand, further complicating the individuals psyche when faced with unimaginable adversity.

Furthermore, the uniformed mental health provider is not only granted the authority in the therapeutic session; however, is often maintaining ultimate authority over the group it's serving—as we see in the case of commissioned military officers treating their enlisted subordinates. This complicates and presents a power differential prior to the uniformed service member ever entering the therapeutic session. As a uniformed mental health provider you have entered into a contractual agreement with the Armed Forces of the United States of America, stating that "the officer is to observe and follow such orders and directions, from time to time, as may be given by the President of the United States of America or Other superior officers, acting

in accordance with the laws of the United States of America." Here, the mission of the organization/system is in fact being fulfilled, as you are charged with assessing, evaluating, and treating a member of the Armed Forces to ensure that all service members are fit for duty in order to fulfill the obligations of the President and the United States of America. If in fact the service member presents to session with symptomatology that may threaten national security or interrupt the military mission, the military mental health provider is obligated to inform the service member's commander, who maintains ultimate authority in the decision making process.

Clinical Presentation in a Military Mental Health Context

Case Vignette

A 35 year old Air Force enlisted technical sergeant presented to the active duty mental health clinic with an extensive history of Post-Traumatic Stress Disorder, Major Depressive Disorder, and suicidality. The Technical Sergeant has been previously diagnosed with PTSD as a result of his military combat experiences. He reported flashbacks, nightmares, hyperactivity, fits of rage, and additional symptomatology to meet diagnostic criteria for PTSD. In addition, he has successfully completed inpatient residential treatment on the Warrior Unit, specifically designated for service members or veterans who have been diagnosed with PTSD as a result of combat trauma.

The Technical Sergeant has been discharged from the residential treatment facility and returns to the active duty installation, and is seen by the active duty Psychiatrist for post discharge follow up and safety evaluation. The service member continues to be on active duty status as he undergoes a medical evaluation board. The medical evaluation board consists of an extensive case review, narrative summary of the diagnostic picture, treatment, and fit for duty evaluation. The service member is expected to be discharged for a service connected disability

and receive a service connection rating. The base Psychiatrist reviews the service member's medications and refers the service member to an active duty social work therapist who is certified in Prolonged Exposure Therapy (PE). PE is considered a front line evidence based treatment by the Department of Defense and Department of Veteran Affairs. The service member agrees to therapy and beginning a PE protocol. When the service member reports to his initial therapy session he is compliant, receptive to starting treatment, and states that he can "jump right in." He takes pride when detailing his "war stories" and is proud of the service he has provided to his country.

After 7 sessions, the therapist learns of a domestic violence referral through the installations Family Advocacy clinic. The service member is a victim of emotional and physical abuse by his female spouse. When the uniformed social work therapist (who is also serving a dual role as the Family Advocacy Officer) approaches the service member with the topic of intimate partner violence, he simply shrugs it off and stares off into the distance. The service member is not willing to engage in dialogue about the incident and does not engage in his usual "fits of rage," however is rather silent. Several sessions later the service member details his childhood trauma of physical, sexual, and emotional abuse by his female caregivers. As sessions progressed, the service member discussed how he would cope with the abuse, often silently, shrugging it off, and focusing on something not pertaining to the act at hand. The service member acknowledged that this was something he never planned to "dig up" and had joined the military to get away from his childhood. He reported being raised in and out of foster care, with abusive caregivers, and this was his only way out. He reported having little to no money while he was in high school and felt that he needed to make something of his self. The technical sergeant

reported that the military was a great way to legally get rid of his anger and that he would become a better man for it.

Case Conceptualization from a Trauma Informed Care Perspective

The above case vignette is a real case intended to highlight the cognitive awareness with dissociated affect. Clients may present with a wide variety of symptoms, such as depression, anxiety, and suicidality; however, focusing solely on treating the symptoms denies importance of the traumatic event(s) and often misses the central issue (Chu, 1991, p. 329). "Therapists ignore this kind of history at their patients' peril. Too much time and effort is spent on fruitless treatment programs to control symptoms such as endless trials of medications, or psychotherapy unrelated to the central issue" (Chu, 1991, p. 329). In the case of the technical sergeant above, he may very well have met diagnostic criteria for military related PTSD; however, it is critical to examine the complexities of the case, and furthermore, fundamentally understand that trauma is complicated. For instance, as we see in the example above, employing Prolonged Exposure Therapy may be clinically indicated given the symptomatology that the service member is presenting with, in addition to the supporting medical record documentation. PE is defined as an evidence based practice through rigorous evidence based research that has been historically funded by the government; both the Department of VA and Department of Defense have completed extensive studies on this topic and even more specifically, this population. However, coming from the notion that trauma is complicated and an inherent human condition, we must be cautious in approaching trauma treatment as a simplistic, one-time event, often referred to as the index trauma. Trauma is a human condition that involves rupture, repair, and support. Social support in all facets of the client's life, extending far beyond a 60-90 minute weekly psychotherapy session. As Felitti (2010) points out:

> The influence of childhood experience, including often-unrecognized traumatic events, is as powerful as Freud and his colleagues originally described it to be. These influences are long-lasting, and neuroscientists are now describing the intermediary mechanisms that develop as a result of these stressors. Unfortunately, and in spite of these findings, the biopsychosocial model and the bio-medical model of psychiatry remain at odds rather than taking advantage of the new discoveries to reinforce each other (p. 14).

This vignette also illustrated the notion of chronic trauma and stress. The service member has experienced a long history of traumatic and stressful experiences. There are countless pre-disposing factors and vulnerabilities present prior to the service member entering the military culture. He had been victimized, abused (sexually, emotionally, physical), experienced minimal positive secured attachments, lived in poverty, and decided to join the military for the betterment of himself, his family, and ultimately his country. Through this process he continued to witness human life at its worst. He was exposed to direct and indirect violence on the battlefield. He witnessed his fellow comrades become permanently disabled, the decimation of women and children, and a violent continuous assault on his psyche. This is trauma, and it is very, very complex. Trauma that cannot be defined by a single definition and often not "fixed" by a single therapeutic modality. As Courtois & Ford (2009) point out:

> complex psychological trauma refers to experiences that (1) involve repetitive or prolonged exposure to, or experiencing of multiple traumatic stressors, most often of an interpersonal design in a variety of milieus and roles; (2) involve harm or abandonment by caregivers or ostensibly responsible adults; and (3) occur at developmentally vulnerable times in the person's life, especially over the course of childhood, and become

> intertwined with an incorporated within the child's biopsychosocial development" (p. 84).

Addressing the system—Public Health Implications of Trauma and Violence

Mental health, and even more specifically, the discipline of social work, has its roots in the military. From the beginnings of the American Red Cross until present, social workers have provided the basic necessities for survival for service members, veterans, and their families. Social work is inherent in the military, and the military is inherent in Social Work. Presently, social workers are increasingly employed in Department of Defense and Department of VA settings. Social workers are not only working in the field at the grassroots level; however, holding positions of power in leadership and management roles. They serve as clinicians, administrators, and policy makers—both directly and indirectly. Mental health has entered mainstream media and our political system, most certainly having a seat at the table. Mental health professionals have power, and must be extremely mindful on how they use their power, especially serving as a subject matter expert on mental health when serving in uniform. Power that transcends far beyond the rank on their collar. Power that is both visible and invisible. Although the military as an organization fundamentally involves violence, stress, adversity, and trauma; this does not mean that mental health does not belong in this context. Now, more than ever, mental health professionals must remain visible, relevant, inform decision, and ultimately assist in preventing psychopathology.

> Although widespread mental and emotional disorders that affect large numbers of people are never eliminated or brought under control by attempts at treating each individual afflicted, and although widespread emotional disorders have been shown to be controllable by successful efforts at prevention, practically all of our current efforts in

> mental health go into individual therapy and almost nothing goes to support efforts at prevention" (Albee, 1982, p. 1044).

Trauma is a part of human existence. We as a profession must examine how we are defining a topic that is often undefinable. Through this process we only continue the historical social reenactments that have always existed. Prevention in the name of the military is difficult and will never be fully achieved. To fully prevent trauma would involve removing all human components—thoughts, emotions, and feelings. Furthermore, promoting a false concept of absolute zero (such as PTSD occurrence, suicides, etc.) sets the clinician, the client, and the system up for failure. The brain is the most complex organ in the human body, allowing the human to critically think, feel, and make decisions on one's own. The concept that the military and even more specifically mental health within the military can control human behaviors perpetuates organizational risk factors. However, social workers can certainly aid in decreasing harm through promoting trauma informed care and the growth of human potential. Care that is focused on education around acknowledging that diagnoses exist for the clinician to makes sense of the complexities that are human thoughts, feeling, and emotions.

Creating an Environment of Stable but Steady Innovation and Change

Social workers must work towards consciously creating an environment that is healing for both the client and the broader system. Rothschild (2011) speaks to treating PTSD in terms of phases and refers to phase one as stabilization and safety:

> In the first stage, the emphasis is on helping trauma survivors to gain control over their symptoms. This is necessary to ensure that the circumstances of an individual's daily life are safe and secure, and that the therapeutic environment and relationship are (and are

> perceived as) safe. Overstatement of the importance of this step is not possible; it is vital if trauma recovery is to be realized (p. 57)

In order to help the service member, we must examine the environment of that individual. The social worker must not avoid acknowledging the harmful and inherent mental health risk factors as part of joining and being in the military. The military mental health provider must create a healing oriented holding environment. An environment that is a safe place, a sanctuary, for the service member to retreat to when the environment around them may seem increasingly violent or chaotic. A safe place to verbalize the normal human emotions to adverse situations. A place that does not patholigize a service member's response into a mental health condition, ultimately reinforcing the stigma, categorizing emotions, and diagnosing the human condition as disorderly. This must be reinforced during mental health military commander briefings, and disseminated by the mental health provider during outreach and prevention events towards the entire installation population; service members, veterans, and their families. Clarity and language matters, and the terminology that we utilize as the subject matter experts holds a significant amount of weight for our clients, their families, the military, and society at large.

George Albee poses an all important question on his piece on Preventing Psychopathology and Promoting Human Potential: "Why is primary prevention such an aversive and frightening concept, such an apparent threat, especially to the psychiatric establishment" (1982, p. 1044). From a trauma informed care perspective, we would likely have to eliminate the all-volunteer force. The history of the military has relied on enlisting an all-volunteer force and placing their recruiting stations in locations of lower socio-economic statuses, often inner city or rural areas. The military offers structure, educational benefits, financial stability, free health insurance, and many additional benefits. However, populations coming from those backgrounds

also have experienced poverty, higher rates of interpersonal violence, and ultimately traumatic experiences. If increased and extensive psychiatric screening protocols were implemented across military entrance processing stations than this could potentially create a conflict. Individuals who meet diagnostic criteria for a mental health disorder prior to entering service are often denied. However, much of the process involves self-report and the service members are aware that if they report a history of mental health symptomatology or treatment, than they will likely fail the medical examination, resulting in not being able to enter service. On the contrary, the military culture and its benefits also has the ability to provide extensive social support, reducing symptomatology, more than any psychotherapeutic protocol could ever provide. A one-one intervention by a qualified mental health professional will not prevent or solve these problems. However, creating discourse around the intersection of the human condition coupled with the entire life course of the military member must exist. It must exist prior to service, during service, and after service. If the professional leans too far into the military or too far into their profession than they are doing the system a complete disservice.

Change starts with education, education that is trauma informed beginning in undergraduate and graduate education for those students interested in providing health care services for military members, veterans, and their families. Being selected and ultimately serving as a commissioned officer in the United States military as a subject matter expert in mental health provides an individual with a tremendous amount of power in facilitating change. This power must be shared with the young men and women serving this great nation, who have entrusted you with aiding them in making sense of the impossible. Creating a culture of blaming the client and categorizing normal human emotions into a single defined diagnosis only increases stigma and promotes psychopathology. We as a profession must educate our students, so in

return they can be conscious of the many competing forces involved in complex trauma and mental health in general. These students will in fact be tomorrow's clinicians, leaders, and military officers, that will be influencing and creating policy surrounding mental health's position in the military and even more importantly the United States of America.

Chapter 7: Methods

Introduction

The social work profession is tasked with providing services for our nation's service members, veterans, and their families in various settings. Social workers serve in uniform as commissioned officers and as civilians in active duty settings both stateside and abroad. They serve in deployed locations, in government and contractual positions, and throughout many community agencies. In addition, many veterans transitioning out of active duty service decide to enter institutions of higher learning through utilization of the Post 9/11 GI Bill, and choose to earn a social work degree in order to continue serving their own. The consequences of war, combat, and other experiences unique to the military population requires "intervention along multiple psychosocial demands" (Olson, 2014, p.1). As a result, the social work profession has been integrated into many facets of military life.

As highlighted in the introductory section and Chapter 1 of this dissertation, despite the increased call and need for military content to be integrated into social work education, there is little content (if any) in the large majority of social work curriculums regarding the unique experiences of military culture and the lifestyle of service members, veterans, and their families. The majority of content is focused around trauma, and even more specifically, posttraumatic stress disorder. However, social workers are called to serve military service members, veterans, and their families throughout all facets of our health care system and beyond. These include the foundations of social work practice; such as, child welfare, mental health, substance abuse, homelessness, prevention programs, and domestic violence. Social workers are in charge of large scale government and civilian programs serving military populations. They hold top-level positions as managers, supervisors, administrators, and clinicians alike. Canfield & Weiss (2015)

refer to the need to integrate military and veteran culture in social work education as "exigent" or demanding attention (p. 128).

Social work can often be conflicted about its role and responsibilities in serving the military populations. Olson (2014) discusses the juxtaposition between social work's advocacy for peace and the call for greater military social work content to be infused into social work curricula, "presenting an ethical dilemma regarding how these disparate positions can be reconciled within social work pedagogy" (p. 183). There are many questions surrounding the ways the social work profession can address the differences between the professions values and military culture, however, Olson (2014) argues "the context bound nature of social work highlights the reciprocal relationship between macro and micro forces intrinsic to military issues" (p. 1). The primary aim of this dissertation is to assist social work education in infusing military content into the social work curricula, in order for students to have the basic skillset to be able to provide competent social work services to military populations regardless of their employed setting(s). The sections below will entail the aim of the curriculum based educational project, learning objectives, its proposed setting, and the pedagogical approach that has been chosen to operationalize the methods in achieving the dissertation aims.

Aim

The primary aim of this dissertation is to create a military social work graduate certificate program guided by the Council on Social Work Education (CSWE) Advanced Social Work Practice in Military Social Work Guidelines (**See Appendix A**). This document was developed specifically "for a military social work concentration and provides the advanced knowledge and practice behaviors needed for those practicing social work with service members, veterans, their families, and their communities" (CSWE, 2010, p.2). The graduate certificate program will

infuse all facets of military social work into the social work curricula. It will consist of active duty social work, veteran social work, and community social work. It includes three elective courses designed to fulfill requirements of the MSW program. This format will allow students to complete their MSW and military social work graduate certificate program simultaneously with no additional coursework required.

Learning Objectives

1) Demonstrate a basic understanding of military culture, command structure, and its impact on psychosocial health
2) Distinguish the difference between social work practice in the active duty and veteran settings
3) Demonstrate a comprehensive understanding of the NASW code of ethics and how to properly address ethical dilemmas in the military environment
4) Recognize the military as the dominant paradigm and how this may lead to confidentiality/privacy issues, dual loyalty conflicts, and secondary trauma
5) Utilize evidence based treatment modalities grounded in empirical research and supported by the Veteran's Affairs administration to aid in providing the best possible trauma therapy and crisis interventions for military members, veterans, and their families
6) Explain how to build resilience in military families, care for bereaved family members, and address the overall health consequences of military service and combat
7) Identify the various psychological, systemic, and organizational barriers to care for military members and their families
8) Demonstrate and evaluate the professional use of self-perspective in clinical practice across multiple systems with military populations, while identifying and making

appropriate use of clinical consultation and supervision, to further the development of a professional identity

9) Demonstrate advanced clinical knowledge of multiple evidence based treatment modalities when working with military service members, veterans, and their families
10) Appropriately uphold and apply the values and ethics of the social work profession to clinical practice situations across multiple systems
11) Apply critical thinking skills and evaluate research findings, agencies, and community practices, to develop and effectively implement evidence informed approaches to military social work interventions.
12) Distinguish their personal values in relation to the national association of social workers code of ethics, specifically the values of self-determination and diversity which illustrates and shapes the military service members, veterans, and military families human experience
13) Develop a working understanding of what is trauma informed care, and how to develop trauma informed communities and trauma specific treatment
14) Demonstrate an understanding of how to develop the skillset to identify and address organizational stress and what creates a trauma informed community
15) Understand the effects adverse childhood experiences and trauma can have on a child's development, behaviors, and eventual adult physical and mental functioning
16) Demonstrate the ability to examine how culture is closely linked with traumatic experiences, responses, and treatment
17) Identify how pre-existing factors, vulnerabilities, and protective factors can influence the adverse impacts of trauma across military populations

18) Distinguish their personal values, understand complex and shared trauma, and how interventions with trauma exposed military populations impact the clinician in working with these populations

Setting

The setting for the military social work graduate certificate program will be at a Master of Social Work Program (MSW) program accredited by the Council on Social Work Education (CSWE) that has a vested interest in educating and training MSW students towards clinical and cultural competence when working with military service members, veterans, and their families. This dissertation proposes that the courses serve as mandatory electives for those students who have applied and been accepted to the military social work graduate certificate program. Students who are enrolled in the certificate program should be placed in a field placement experience that will enhance their skills practicing directly with military service members, veterans, or their families.

Operational Outline

The steps listed below are intended to meet the aims of the dissertation

1. **Examine the current state of military social work education and the historical and contemporary relationship of the military and the social work profession-** The social work profession is seen throughout all aspects of military life. The social worker provides services throughout the entire life span of the military member, from the moment the military member puts on the uniform and through end of life care. The social worker is available to military members and their families in active duty settings, VA, and many additional government and community agencies. In an effort to illustrate the important role of the military social worker and the urgent need to infuse military content in social

work curricula, various journal articles, texts, and social work statistics were obtained and examined. The materials were obtained through electronic databases. Various social work web based information and texts supported the argument that social work organizations have failed to highlight and disseminate information and skills to assist social workers in providing the most competent care for military populations.

2. **Current clinical interventions and best evidence- based practices with service members, veterans, and their families-** The dissertation highlighted various evidence-based practices and interventions with military populations and took a critical approach in examining the medicalized model of military mental health in a cultural context.
3. **Examine the social work role in veteran reintegration and transitional services-** An examination of various journals and texts from multiple disciplines was employed in an attempt to understand the veteran's developmental processes, predisposing factors, and vulnerabilities that often exacerbate military related trauma. The many transitional resources available to our nation's veterans and the many social work implications was also examined.
4. **The culmination of steps 1 through 3-** The Council on Social Work Education Advanced Social Work Practice in Military Social Work Guidelines were utilized in conjunction with the steps above to form the conceptual framework for the three military social work courses. These courses are intended to follow the dissertation outline closely. The first course will consist of a basic overview of military culture and social work practice. The second course will focus primarily on current clinical interventions and evidence-based practices with military populations and the impact of military service on the entire family unit. The final course will be both macro policy and clinically focused

on the social workers role in serving veterans through reintegration, transitional services, and long-term care.

Pedagogical Approach

The military social work program will utilize the following resources to fulfill the requirements of the social work practice behaviors and support the curriculum.

1. **Class Lectures**- in class lectures will consist of the topics outlined in the dissertation and class syllabi. The historical and contemporary relationship of the military and social work profession will be explored. Students will be introduced to current clinical interventions and evidence based practices with military populations. Students will also examine the social workers role in veteran reintegration, transitional services, and ongoing care.
2. **Guest Speakers/Presentations**-speakers with first-hand experience and knowledge of military culture will be invited to enhance class discussions. Social workers and other mental health disciplines with experience working with service members, veterans, and their families will also provide first-hand accounts to students.
3. **Reading Leadership**- students will create discussion questions based on the required reading for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and military social work practice.
4. **Case Vignettes**-students will be provided with case vignettes to enhance student learning and provide a thorough examination of the social workers role in providing services to

service members, veterans, and their families. Case vignettes will explore topics such as ethics, client confidentiality, provider burnout, the role of the uniformed social worker, and the relationship between the social work profession and the military.

5. **Assignments/Class Presentations**-students will be required to complete assignments on the various topics explored throughout the curriculum in order to evaluate their knowledge and skill-set of the information covered. Students will also have the opportunity to present their assignments to the class and stimulate student engagement and class learning.
6. **Course Readings-**students will be assigned various class readings on a range of topics that will accompany class lectures, guest speakers, and assignments. Readings are intended to enhance student knowledge of best evidence based practice(s) when providing care for service members, veterans, and their families.
7. **Multimedia-** videos will be viewed in the classroom and assigned for homework to aid students learning and highlight psychosocial issues faced by military populations.

Evaluation

The aims of the curriculum will be evaluated through class assignments, written papers, class presentations, and assigned reading leadership discussions. This format allows students to provide feedback and enhance student engagement regarding military culture and social work practice, evidence-based approaches, and to critically evaluate the historical and contemporary relationship between the social work profession and the military. Students will be asked to complete a formal and anonymous evaluation following completion of the class.

Reflexivity

I have worked with service members, veterans, and their families as an active duty uniformed social worker, in the Veteran Affairs System, and community agencies. As an advocate for this population and the critical role of the social worker in providing care for this population, I believe there is a lack of in-depth educational opportunities in schools of social work at institutions of higher learning. We must recognize the unique psychosocial issues and culture presented by the service member, veteran, and their families and develop the necessary educational opportunities to promote clinical and cultural competence in the field of military social work.

I have provided care for active duty service members, veterans, and their families in areas such as: mental health, substance abuse prevention and treatment, suicide prevention, domestic violence, military sexual assault, and veteran homelessness. My experiences in these areas are very personal and professional and have led me to pursue this dissertation to contribute to the knowledge base that has been directed by empirical data. This dissertation is an effort to educate and train social work students towards clinical and cultural competence with service members, veterans, and their families by providing them with content that has been accurately infused in social work curricula and grounded in the professions code of ethics and values.

Chapter 8

Course 1: Introduction to Military Culture and Social Work Practice

Chapter 8 provides a conceptual outline for the initial course in the military social work graduate certificate program. The format is intended to be an introduction to military culture, lifestyle, and its intersection with social work practice. The course will be a basic foundational overview of the history of social work in military contexts and the numerous roles social workers have providing services for active duty military, veterans, and their families. The following sections in Chapter 8 highlights course description, learning objectives, required readings to enhance student learning, course requirements, assignments, and weekly course schedule.

Curriculum Outline and Course Description

I. AUDIENCE

This course is designed for graduate students interested in gaining knowledge of military culture and advancing skills in the field of military social work.

II. COURSE DESCRIPTION

Introduction to military culture and social work practice with military service members, veterans, and their families. Designed to assist students in understanding military culture and to provide clinically and culturally competent services to military populations.

III. ADDITIONAL COURSE DESCRIPTION

The course will include a brief history of social work practice with military service members, veterans, and their families. Students will gain an understanding of the unique demands of the military and its influence on the service member and the social worker. It will entail a thorough review of command structure, the NASW code of ethics, and ethical dilemmas

social workers encounter when working in a military environment. The course will examine the many complex aspects of trauma and available evidence based treatment modalities. In addition, the course will highlight the effects of trauma on the entire family unit, impacting children and spouses. The role of psychological stigma, systemic, and organizational barriers to care will be explored. The course will focus on the social workers role in assisting the service member with reintegration back into the civilian sector and access to VA care.

IV. LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Demonstrate a basic understanding of military culture, command structure, and its impact on psychosocial health
2. Distinguish the difference between social work practice in the active duty and veteran settings
3. Demonstrate a comprehensive understanding of the NASW code of ethics and how to properly address ethical dilemmas in the military environment
4. Recognize the military as the dominant paradigm and how this may lead to confidentiality/privacy issues, dual loyalty conflicts, and secondary trauma
5. Utilize evidence based treatment modalities grounded in empirical research and supported by the Veteran's Affairs administration to aid in providing the best possible trauma therapy and crisis interventions for military members, veterans, and their families
6. Explain how to build resilience in military families, care for bereaved family members, and address the overall health consequences of military service and combat
7. Identify the various psychological, systemic, and organizational barriers to care for military members and their families

V. REQUIREMENTS

A. Bibliography/ Texts / Supplies – Required:

Marlantes, K. (2011). *What it is like to go to war*. Grove/Atlantic, Inc.

Rubin, A., Weiss, E. L., & Coll, J. E. (Eds.). (2012). *Handbook of military social work*. John Wiley & Sons.

Other Required Reading:

Required journal articles or chapters ***not in*** the required books above are accessible via Blackboard.

VI. CLASS ASSIGNMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

Class Attendance, Participation, & Discussion Leadership (10 pts): Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership.

Discussion Leadership: Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to

providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and military social work practice.

Learning Outcomes # 1-7

Competency and practice behaviors related to assignment

Assignment 1 (20 pts): Case Vignette/Ethical Decision Making in Military Social Work

Students will be provided a case vignette and be required to answer discussion questions pertaining to their specific case example. Students will submit a 3-5 page paper utilizing models for ethical decision making, make ethical decisions by applying the standards of the NASW Code of Ethics, and write on how they would use supervision and consultation to guide professional judgment and behavior.

Learning Outcomes: # 1, 3, 4, 7

Assignment 2 (30 pts): Reflection Paper (Due

Students will submit a 3-5 page reflection paper on *What It Is like to go to War by Karl Marlantes,* in regards to military training, culture, combat, and its implications for social work practice. The following are some questions to guide you when you write: Do you believe this book served as a therapeutic tool for the author? What themes emerged to you as the reader? What did it make you realize or rethink about military culture and implications for social work practice? Marlantes "needed desperately to be accepted back in" (p.184), how can the social worker assist in the meaning making process and reintegration back into the civilian sector? What are some of the health consequences that emerge as a result of military service and combat? Professional social workers have been working as uniformed members of the military

since WWII, what are some ethical challenges the social worker may experience in the deployed setting?

Learning Outcomes: # 1, 4, 6, 7

Assignment 3 (40 points): Military Service Interview and Presentation

Paper (30 points)

Presentation (10 points)

Students must select a current active duty service member or veteran to interview. Students must select their interviewee prior to session 6 of this course. Students must get approval from the instructor. Please utilize the questions below as an interview guide. This guide is not meant to be exhaustive, and some questions may not apply to your interviewee. This is meant to be an interview guide to aid in developing a framework for your paper and presentation.

Papers should be between 7-8 pages, double-spaced, 12 point font, Times New Roman, and APA format. Students will also conduct a 15-20 minute class presentation developed from their interview, integrating course content. The presentation can be in any format. Power points, verbally from a script, and videos are all acceptable formats.

Interview Guide

1) Identify all demographic characteristics; such as, branch of service, military occupation, rank, age at service entry, age at separation/retirement, status (active duty, reserve, veteran), race, gender, ethnicity.
2) Ask the interviewee their status prior to entering military service.
    a. Educational status, occupational status, financial status, home of record, religion, family life, belief systems, values, and traditions

   b. Keep in mind any predisposing factors or vulnerabilities present prior to service

3) Why did the interviewee choose to enter military service?
4) What military installation(s) was the interviewee stationed at throughout their time of service? Were they stationed overseas? Was the interviewee ever deployed? If so, what was their experience of the deployment? How did the mission or culture change at each installation?
5) Ask the interviewee if/how their personal traditions, core belief system, values, and culture has changed from the time they entered the military and throughout the course of their career. Was this a positive or negative impact on their personal life?
6) What was/is the impact on the service member or veteran's family unit? Does the interviewee feel that there was a positive or negative relationship between the military mission and their family life? Ask the interviewee about their children and spouses. For example, did the interviewee's children attend Department of Defense schools, installation youth centers, daycare, etc.? Was the spouse employed during military service?
   a. For this section, if possible, ask the interviewee if you could briefly interview their spouse or children about their experiences with military lifestyle and culture.
7) What has the transition(s) been like for the interviewee? If the member is still actively serving, what are the challenges they face from moving often, overseas, or short term tours without their family? If the interviewee is a veteran, ask them to describe their transition and reintegration back into the civilian sector. What are some of the challenges they faced throughout the transitioning process? Do they have experience with the VA system or other community based agencies serving veterans? Have they utilized the

Montgomery or Post 9/11 GI Bill, VA home loans, or other transitional options available to veterans?

8) Discuss your experience while interviewing the service member or veteran. What was the experience like for you? How did the interview enhance your learning about military culture and aid in understanding to enhance your social work practice with service members, veterans, and their families?

Learning Outcomes: # 1, 2, 4, 6, 7

Competency and practice behaviors related to assignment

Grading:

Class Participation:	10 pts
Assignment One:	20 pts
Assignment Two:	30 pts
Assignment Three:	40 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers: Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects

students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Weekly Course Topics and Readings

T=Located in course required textbook(s)

B=Located on blackboard

Week #1- Course Introduction & the Culture of Military Life

- **(T)** Rubin Weiss & Coll: Chapter 2
- **(T)** Marlantes: Chapters 1, 2
- **(B)** Petrovich, J. (2012). Culturally competent social work practice with veterans: An overview of the US Military. *Journal of human behavior in the social environment*, *22*(7), 863-874.

Week #2- History of Social Work with Service Members, Veterans, & their Families

- **(T)** Rubin Weiss & Coll: Chapter 1 & 18
- **(T)** Marlantes: Chapters 3, 4
- **(B)** Savitsky, L., Illingworth, M., & DuLaney, M. (2009). Civilian social work: Serving the military and veteran populations. *Social Work*, *54*(4), 327-339.

Week #3- Military Social Work Ethics Part 1

- **(T)** Rubin Weiss & Coll: Chapter 4
- **(T)** Marlantes: Chapters 5, 6

- **(B)** Simmons, C. A., & Rycraft, J. R. (2010). Ethical challenges of military social workers serving in a combat zone. *Social work, 55*(1), 9-18.

Week #4-Military Social Work Ethics Part 2

- **(B)** Johnson, W. B., Grasso, I., & Maslowski, K. (2010). Conflicts between ethics and law for military mental health providers. *Military medicine, 175*(8), 548-553.
- **Assignment 1 Due:** Ethical Decision Making in Military Social Work/Case Vignette Paper & Class Discussions

Week #5-Military Crisis Intervention

- **(T)** Rubin, Weiss & Coll: Chapter 14
- **(T)** Marlantes: Chapters 7, 8
- **(B)** Bryan, C. J., Jennings, K. W., Jobes, D. A., & Bradley, J. C. (2012). Understanding and preventing military suicide. *Archives of Suicide Research*, *16*(2), 95-110.
- **(B)** VA Pocket Guide/Suicide
- View documentary on *Veterans Press 1*

Week #6-Preventing, Assessing, and Treating Substance Use Disorders in Military Populations

- **(T)** Rubin, Weiss, & Coll: Chapters 12, 13
- **(T)** Marlantes: Chapters 9, 11
- **(B)** VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders

Week #7-Domestic Violence in the Military

- **(T)** Rubin, Weiss & Coll: pp. 11-13, 306, 324-328
- **(B)** Marshall, A. D., Panuzio, J., & Taft, C. T. (2005). Intimate partner violence among

military veterans and active duty servicemen. *Clinical psychology review*, *25*(7), 862-876.

- **(B)** Review worksheet prior to class: Principle Elements of Strategic Plan for More Effectively Addressing Domestic Violence Matters within the DoD

Week #8- Building Resilience in Military Personnel

- **(B)** Whealin, J. M., Ruzek, J. I., & Vega, E. M. (2013). Cognitive behavioral methods for building resilience.
- **(B)** Bartone, P. T. (2006). Resilience under military operational stress: can leaders influence hardiness?. *Military Psychology*, *18*(S), S131.
- **(B)** Britt, T. W., & Oliver, K. K. (2013). Morale and cohesion as contributors to resilience.
- **Assignment 2 Due:** Reflection Paper

Week #9- PTSD & Evidence Based Treatments

- **(B)** Sharpless, B. A., & Barber, J. P. (2011). A clinician's guide to PTSD treatments for returning veterans. *Professional Psychology: Research and Practice*, *42*(1), 8.
- **(B)** Keane, T. M., Niles, B. L., Otis, J. D., & Quinn, S. J. (2011). Addressing posttraumatic stress disorder in veterans: The challenge of supporting mental health following military discharge.
- View 60 Minutes Video-Advanced PTSD Therapy

Week #10-Military Families Impacted by Military Service

- **(T)** Rubin, Weiss, & Coll: Chapters 19, 22, 24, 26

- **(B)** Palmer, C. (2008). A theory of risk and resilience factors in military families. *Military Psychology*, *20*(3), 205.

Week #11- Women Service Members & Veterans/Military Sexual Trauma

- **(T)** Rubin, Weiss, & Coll: Chapter 3
- **(B)** Conard, P. L., Young, C., Hogan, L., & Armstrong, M. L. (2014). Encountering women veterans with military sexual trauma. *Perspectives in psychiatric care*, *50*(4), 280-286.
- **Film-** The Invisible War

Week #12- Veteran Social Work, Reintegration, & Transitional Care

- **(T)** Rubin, Weiss, & Coll: Chapters 15-17 (pp. 247-281)
- **(B)** Wheeler, D. P., & Bragin, M. (2007). Bringing it all back home: Social work and the challenge of returning veterans. *Health & Social Work*, *32*(4), 297-300.

Week #13-Addressing Secondary Trauma, Provider Burnout, & Self- Care for Military Social Workers

- **(T)** Rubin, Weiss, & Coll: Chapter 5
- **(B)** Lester, P. B., Taylor, L. C., Hawkins, S. A., & Landry, L. (2015). Current Directions in Military Health-care Provider Resilience. *Current psychiatry reports*, *17*(2), 1-7.
- **(B)** Linnerooth, P. J., Mrdjenovich, A. J., & Moore, B. A. (2011). Professional burnout in clinical military psychologists: Recommendations before, during, and after deployment. *Professional Psychology: Research and Practice*, *42*(1), 87.
- **(B)** Harrington, D., Bean, N., Pintello, D., & Mathews, D. (2001). Job satisfaction and burnout: Predictors of intentions to leave a job in a military setting. *Administration in Social Work*, *25*(3), 1-16.

Week # 14- Class Presentations & Course Wrap-Up

- **Assignment #3 Due**

Chapter 9

Course 2: Advanced Clinical Mental Health Practice with Military Service Members, Veterans, and their Families

Chapter 9 provides a conceptual outline for the second course in the military social work graduate certificate program. The second course is intended to be an advanced clinical course focused on critically examining the professional use of self when serving military populations, a critical look at available evidence based practices, effective implementation, diversity and cultural implications in practice. The advanced course will build upon the introductory military course content and foster critical thought surrounding topics on clinical and cultural competence when serving diverse military populations. The following sections in Chapter 9 highlights course description, learning objectives, required readings to enhance student learning, course requirements, assignments, and weekly course schedule.

Curriculum Outline and Course Description

I. AUDIENCE

This course is designed for graduate students interested in gaining knowledge of evidence based practices and advancing clinical skills in the field of military mental health practice.

II. COURSE DESCRIPTION

Advanced clinical mental health practice with military service members, veterans, and their families. Designed to assist students in learning advanced clinical skills and methods necessary for working with diverse military populations.

III. ADDITIONAL COURSE DESCRIPTION

The course emphasizes the professional use of self, and critically examines evidence based practice modalities, specifically examining diversity and the cultural implications in

practice. Students will learn principles and application of Cognitive Behavioral Therapy (CBT), Prolonged Exposure Therapy (PE), group treatment approaches, and additional evidence based treatment modalities and clinical practice with military families. The course will include content and dialogue on clinical and cultural competence when serving a diverse population within our nation's military. Class sessions will build on knowledge from other courses within the program and integrate experiences from field placements, case conceptualizations, and feedback from peers and instructor.

IV. LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Demonstrate and evaluate the professional use of self-perspective in clinical practice across multiple systems with military populations, while identifying and making appropriate use of clinical consultation and supervision, to further the development of a professional identity
2. Demonstrate advanced clinical knowledge of multiple evidence based treatment modalities when working with military service members, veterans, and their families
3. Appropriately uphold and apply the values and ethics of the social work profession to clinical practice situations across multiple systems
4. Apply critical thinking skills and evaluate research findings, agencies, and community practices, to develop and effectively implement evidence informed approaches to military social work interventions.
5. Distinguish their personal values in relation to the national association of social workers code of ethics, specifically the values of self-determination and diversity which illustrates

and shapes the military service members, veterans, and military families human experience

V. REQUIREMENTS

A. Bibliography/ Texts / Supplies – Required:

Castner, B. (2013). The long walk: A story of war and the life that follows. Anchor Books.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged Exposure Therapy for PTSD: Therapist Guide: Emotional Processing of Traumatic Experiences*. Oxford University Press

Other Required Reading:

Required journal articles or chapters ***not in*** the required books above are accessible via Blackboard.

VI. CLASS ASSIGNMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

Class Attendance, Participation, & Discussion Leadership:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership.

Assignment 1

Part 1 (10 Points) Blackboard Discussion:

Your class participation through blackboard discussion and reading leadership will be essential to the learning process. These activities are a class requirement and will contribute to your final grade. Students are required to create an original post in response to the appropriate week's readings and engage in commenting on your classmates posts.

Learning Outcomes # 1, 2, 3, 4, 5

Part 2 Reading Leadership (10 Points):

Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading(s) for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and advanced clinical practice with military populations.

Learning Outcomes # 1, 2, 3, 4, 5

Assignment 2 (20 pts): Journal Entries and Reflection Paper

Students will be required to maintain an active journal entry for each weeks assigned reading for the following text: *The long walk: A story of war and the life that follows.* Each journal entry should be no more than one page double spaced. Journal entries should include critical thought on how the content relates to advanced clinical mental health practice with military populations. Entries should include but not limited to the following themes: military culture, mental health

practice, possible clinical approaches or interventions, the effect on the military family, transitioning back to the civilian sector, guilt, isolation, values, and ethics.

There should be a total of five journal entries and a 1-2 page reflection at the conclusion of the journal entries. The assignment is due at session 6 and should be no more than seven pages. Students will be expected to share their journal entries and reflection of the literature during session 6 of the course.

Learning Outcomes: # 1, 3, 5

Assignment 3 (30 pts): Midterm Exam in Class #8

This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Learning Outcomes: # 1, 2, 3, 4, 5

Assignment 4 (30 points): Final Paper and Presentation

Final Paper (20 points)

Presentation (10 points)

Students will be provided a case study by week 10. Please utilize the topics below as a guide for your case formulation paper and presentation. This is meant to be a guide to aid in developing a framework for your paper and presentation.

Papers should be between 5-7 pages, double-spaced, 12-point font, Times New Roman, and APA format. Students will also conduct a 15-20 minute class presentation developed from their paper,

integrating course content. The presentation can be in any format. Power points, verbally from a script, and videos are all acceptable formats.

Case Formulation Guide

1) Given the provided case information, how would you work to develop a therapeutic relationship with the client? Integrate the literature on professional use of self (See week 1 readings).
2) Identify how you would make appropriate use of clinical consultation and supervision regarding the presented case study.
3) Highlight your personal values in relation to the NASW code of ethics, specifically the values of self-determination and diversity. Identify any potential cultural, social, and familial implications and how that may impact the therapeutic relationship, intervention, and overall treatment.
4) Identify a working or provisional diagnosis. Utilize the DSM 5 criteria to support your diagnosis. Do you view the diagnosis as a positive or negative in the healing process? Explain why.
5) Which intervention would you select for the client? Provide reasoning. For example, would you select CBT, PE, MI, group treatment, or an integration of multiple interventions, etc.
6) Introduce reasoning for selecting the intervention and share with your client. Provide research, background information, and how you would assist in educating your client about the selected intervention.

7) Would you refer any services out or elect to operate within a multidisciplinary approach? Explain why.

8) Identify potential roadblocks to treatment that you may anticipate. In addition, identify your assumptions, any countertransference, ethical, or legal dilemmas.

Learning Outcomes: # 1, 2, 3, 4, 5

Grading:

Assignment one

Part 1 10 pts

Part 2 10 pts

Assignment Two: 20 pts

Assignment Three: 30 pts

Assignment Four: 30 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers: Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Weekly Course Topics and Readings

T=Located in course required textbook(s)

B=Located on blackboard

Week #1- Professional Use of Self with Military Populations

- **(T)** Castner: Chapters 1-2
- **(B)** Arnd-Caddigan, M., & Pozzuto, R. (2008). Use of self in relational clinical social work. *Clinical Social Work Journal, 36*(3), 235-243.
- **(B)** Dewane, C. J. (2006). Use of self: A primer revisited. *Clinical Social Work Journal, 34*(4), 543-558.
- **Week #2- Evidence or Cultural Based Practice: A critical look**
- **(T)** Castner: Chapter 2-4
- **(B)** Scandlyn, J. N. (2012). THE CANON-3: The harmony of illusions: Inventing post-traumatic stress disorder, by Allan Young. Anthropology & medicine, 19(1), 129-131.
- **(B)** Behrouzan, O. (2015). Medicalization as a way of life: The Iran-Iraq War and considerations for psychiatry and anthropology. Medicine Anthropology Theory, 2(3), 40-60.
- **(B)** Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health*, *8*(1), 34-45.

- **Week #3- Introduction to Cognitive Behavioral Therapy with Military Populations**
- **(T)** Castner: Chapters 5-7
- **(B)** Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., & Wilkinson, E. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. *American journal of psychiatry*, *172*(5), 441-449.
- **(B)** van Doorn, K., McManus, F., & Yiend, J. (2012). An analysis of matching cognitive-behavior therapy techniques to learning styles. *Journal of Behavior Therapy and Experimental Psychiatry*, *43*, 1039-1044.

Week #4-Cognitive Behavioral Therapy Application

- **(T)** Castner: Chapters 8-9
- **(B)** Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual. Washington, DC: U.S. Department of Veterans Affairs.
    - Read pages 3-35

Week #5-Prolonged Exposure Therapy with Military Populations: An Introduction

- **(T)** Castner: Chapters 8-9
- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 1-2
- **Assignment 2 Due:** Journal Entries and Reflection Paper

  Paper and Class Discussions

Week #6-Prolonged Exposure Therapy: Sessions 1-3

- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 3-5

- Review Trauma Interview: Appendix A

Discussion of PTSD web based application

Week #7-Prolonged Exposure Therapy: Intermediate, Final Session, & Case Studies

- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 6-8
- **(B)** Tuerk, P. W., Yoder, M., Grubaugh, A., Myrick, H., Hamner, M., & Acierno, R. (2011). Prolonged exposure therapy for combat-related posttraumatic stress disorder: An examination of treatment effectiveness for veterans of the wars in Afghanistan and Iraq. *Journal of anxiety disorders*, *25*(3), 397-403.

Week #8- Mid-Term Examination

*****This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Week #9- Motivational Interviewing and Group Treatment

- **(B)** Britt, E., Hudson, S. M., & Blampied, N. M. (2004). Motivational interviewing in health settings: a review. *Patient education and counseling*, *53*(2), 147-155.
- **(B)** Hagedorn, W. B. & Hirshhorn, M. A. (2009). When talking won't work: Implementing experiential group activities with addicted clients. *The Journal for Specialists in Group Work, 34*(1), 43-67.
- **(B)** Resnicow, K., DiIorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational interviewing in health promotion: it sounds like something is changing. *Health Psychology*, *21*(5), 444.

- **(B)** Sloan, D. M., Bovin, M. J., & Schnurr, P. P. (2012). Review of group treatment for PTSD. *Journal of Rehabilitation Research and Development*, *49*(5), 689-701.

Week #10-Veteran Affairs, Peer Support Services, and Group Treatment

- **(B)** Barber, J. A., Rosenheck, R. A., Armstrong, M., & Resnick, S. G. (2008). Monitoring the dissemination of peer support in the VA Healthcare System. *Community mental health journal*, *44*(6), 433-441.
- **(B)** Greden, J. F., Valenstein, M., Spinner, J., Blow, A., Gorman, L. A., Dalack, G. W., & Kees, M. (2010). Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. *Annals of the New York Academy of Sciences*, *1208*(1), 90-97.
- **Guest Presentation**

  *Final Assignment case study to be provided to students during session 10

Week #11- Housing First—An Evidence Based Practice to Ending Veteran Homelessness

- **(B)** Kertesz, S. G., Austin, E. L., Holmes, S. K., DeRussy, A. J., Van Deusen Lukas, C., & Pollio, D. E. (2017). Housing first on a large scale: Fidelity strengths and challenges in the VA's HUD-VASH program. *Psychological services*, *14*(2), 118.
- **(B)** Metraux, S., Cusack, M., Byrne, T. H., Hunt-Johnson, N., & True, G. (2017). Pathways into homelessness among post-9/11-era veterans. *Psychological services*, *14*(2), 229.
- **(B)** Tsai, J., O'toole, T., & Kearney, L. K. (2017). Homelessness as a public mental health and social problem: New knowledge and solutions. *Psychological services*, *14*(2), 113.

- **(B)** Tsemberis, S. (2010). *Housing first: The pathways model to end homelessness for people with mental illness and addiction manual*. Hazelden.

Week #12- The Military Family—Part 1

- **(B)** Asbury, E. T., & Martin, D. (2012). Military deployment and the spouse left behind. *The Family Journal*, *20*(1), 45-50.
- **(B)** Riggs, S. A., & Riggs, D. S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of Family Psychology*, *25*(5), 675.

Week #13-The Military Family—Part 2 & Class Presentations

- **(B)** Altshuler, J. L., & Ruble, D. N. (1989). Developmental changes in children's awareness of strategies for coping with uncontrollable stress. *Child development*, 1337-1349.
- **(B)** Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics*, *125*(1), 16-25.
- Make the Connection Video

Week # 14- Class Presentations & Course Wrap-Up

- **Final Assignment Due**

Chapter 10

Course 3: Trauma Informed Care for Military Populations

Chapter 10 provides a conceptual outline for the third course in the military social work graduate certificate program. The third course focuses on the history of the military system as it relates to trauma and how it functions today. The trauma informed care course will build upon the introductory military course content and the advanced clinical mental health course, emphasizing the importance of understanding complex trauma and shared trauma. The course will culminate with content on leadership for change within the social work profession and how to effectively develop trauma informed communities and trauma specific treatment. The following sections in Chapter 10 highlights course description, learning objectives, required readings to enhance student learning, course requirements, assignments, and weekly course schedule.

Curriculum Outline and Course Description

I. AUDIENCE

This course is designed for graduate students interested in gaining knowledge of trauma informed care for military populations and how to effectively develop trauma informed care communities and trauma specific treatment for military populations.

II. COURSE DESCRIPTION

Trauma informed care for military populations. The course provides an introduction to trauma informed care for military populations, while highlighting the adverse childhood experiences research and post-traumatic stress disorder.

III. ADDITIONAL COURSE DESCRIPTION

The course will analyze the military mental system through clinical case conceptualizations, specifically examining clinical presentations in a military mental health context. The course will concentrate on the topic areas of military sexual trauma, interpersonal violence and combat, military related intimate partner violence survivors, and trauma informed care for homeless veterans. Class sessions will build on knowledge from other courses within the program and integrate experiences from field placements, case conceptualizations, and feedback from peers and instructor.

IV. LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Develop a working understanding of what is trauma informed care, and how to develop trauma informed communities and trauma specific treatment
2. Demonstrate an understanding of how to develop the skillset to identify and address organizational stress and what creates a trauma informed community
3. Understand the effects adverse childhood experiences and trauma can have on a child's development, behaviors, and eventual adult physical and mental functioning
4. Demonstrate the ability to examine how culture is closely linked with traumatic experiences, responses, and treatment
5. Identify how pre-existing factors, vulnerabilities, and protective factors can influence the adverse impacts of trauma across military populations
6. Distinguish their personal values, understand complex and shared trauma, and how interventions with trauma exposed military populations impact the clinician in working with these populations

V. REQUIREMENTS

A. Bibliography/ Texts / Supplies – Required:

Kraft, H. S. (2007). Rule number two: Lessons I learned in a combat hospital. Little, Brown.

Rothschild, B. (2011). Trauma essentials: The go-to guide. WW Norton & Company.

Other Required Reading:

Required journal articles or chapters ***not in*** the required books above are accessible via Blackboard.

VI. CLASS ASSIGNMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

Class Attendance, Participation, & Discussion Leadership:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership.

Assignment 1

Part 1 (10 Points) Blackboard Discussion:

Your class participation through blackboard discussion and reading leadership will be essential to the learning process. These activities are a class requirement and will contribute to your final grade. Students are required to create an original post in response to the appropriate week's readings and engage in commenting on your classmates posts.

Learning Outcomes # 1, 2, 3, 4, 5, 6

Part 2 Reading Leadership (10 Points):

Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading(s) for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and advanced clinical practice with military populations.

Learning Outcomes # 1, 2, 3, 4, 5, 6

Assignment 2 (10 pts): Reflection Paper

Students will submit a 5-7 page reflection paper on, *Rule number two: Lessons I learned in a combat hospital.* The reflection paper should focus on topics and themes discussed throughout the course such as; trauma informed care, analyzing and addressing the military system, public health implications of trauma and violence, complex trauma, and shared trauma. A reflection or journal should be completed each week. Each entry should be no more than one page and the final paper will be due by week 7 of the course.

Learning Outcomes: # 1, 4, 5, 6

Assignment 3 (30 pts): Midterm Exam in Class #8

This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Learning Outcomes: # 1, 2, 3

Assignment 4 (40 points): Executive Summary and Presentation

Please refer to the following publications for your executive summary and final presentation:

(1) Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies, Incorporated.

(2) Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Executive Summary (20 points)

The executive summary should be 5-7 pages in length. The intent of the executive summary is to provide a clear and concise written version of your presentation. The goal of the summary is to identify the key ingredients and barriers for successful trauma-informed care implementation at your field placement agency or organization. The first part of the paper should address the system you are analyzing. It should address the history, values, mission, and what you have uncovered about how the system resists change or deals with loss. The paper should also include whether or not the employees and clients feel safe in the environment. Discuss what trauma informed service delivery would mean for clients, staff, and the organization. The executive summary should address the six key principles of trauma informed approach as it pertains to your specific identified agency: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues. The executive summary should also incorporate guidance for your agency on how to implement a trauma-informed approach through use of the ten implementation domains.

Presentation (20 Points)

The presentation portion of the assignment should be of high quality and stem from your executive summary. It should consist of understanding how to effectively implement trauma informed care practices into current agency functioning. The presentation should be clear, concise, and demonstrate the vital importance of having trauma informed organizations. The presentation should be designed for front line supervisors, managers, team leaders, and executive leadership. Presentations will be no longer than 20 minutes in duration.

Below is a guide for your presentation and is not meant to be exhaustive.

- Provide an overview of trauma informed care.
- Define and provide examples of trauma—Include Adverse Childhood Experiences Literature.
- How do you plan to educate your agency about trauma informed care practices?
- How would you complete a self-assessment of your agency and identify training needs? Explain why this is important.
- Who would conduct the required trainings?
- How would you engage supervisors and executive leadership?
- Explain how you would evaluate the organizations effectiveness of implementing Trauma Informed Practices.
- How would you ensure your agency remains trauma informed care after its initial implementation? How would you train new staff and provide booster sessions or continuing education opportunities? Would there be required trainings for all staff?
- Provide a list of Trauma Informed Care resources for your organization.

Learning Outcomes: # 1, 2, 3, 4, 5, 6

Grading:

Assignment one

Part 1 10 pts

Part 2 10 pts

Assignment Two: 10 pts

Assignment Three: 30 pts

Assignment Four: 40 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers: Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Weekly Course Topics and Readings

T=Located in course required textbook(s)

B=Located on blackboard

Week #1- What is Trauma Informed Care: An Introduction and Overview

- **(T)** Kraft: pp. 7-35
- **(B)** Albee, G. W. (1982). Preventing psychopathology and promoting human potential. American psychologist, 37(9), 1043.
- **(B)** Purtle, J. (2014). The legislative response to PTSD in the United States (1989–2009): A content analysis. Journal of traumatic stress, 27(5), 501-508.

Week #2- Adverse Childhood Experiences and Military Service

- **(T)** Kraft: pp. 36-71
- **(B)** Blosnich, J. R., Dichter, M. E., Cerulli, C., Batten, S. V., & Bossarte, R. M. (2014). Disparities in adverse childhood experiences among individuals with a history of military service. JAMA psychiatry, 71(9), 1041-1048.
- **(B)** LeardMann, C. A., Smith, B., & Ryan, M. A. (2010). Do adverse childhood experiences increase the risk of postdeployment posttraumatic stress disorder in US Marines?. BMC Public Health, 10(1), 437.
- **(B)** Montgomery, A. E., Cutuli, J. J., Evans-Chase, M., Treglia, D., & Culhane, D. P. (2013). Relationship among adverse childhood experiences, history of active military service, and adult outcomes: homelessness, mental health, and physical health. American journal of public health, 103(S2), S262-S268.
- **Week #3- ACES, Combat, and Posttraumatic Stress Disorder**
- **(T)** Kraft: pp. 72-113

- **(B)** Cabrera, O. A., Hoge, C. W., Bliese, P. D., Castro, C. A., & Messer, S. C. (2007). Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. American journal of preventive medicine, 33(2), 77-82.
- **(B)** Clancy, C. P., Graybeal, A., Tompson, W. P., Badgett, K. S., Feldman, M. E., Calhoun, P. S., ... & Beckham, J. C. (2006). Lifetime Trauma Exposure in Veterans With Military-Related Posttraumatic Stress Disorder: Association With Current Symptomatology.[CME]. Journal of Clinical Psychiatry, 67(9), 1346-1353.
- **(B)** Sareen, J., Henriksen, C. A., Bolton, S. L., Afifi, T. O., Stein, M. B., & Asmundson, G. J. G. (2013). Adverse childhood experiences in relation to mood and anxiety disorders in a population-based sample of active military personnel. Psychological Medicine, 43(1), 73-84.

Week #4-Analyzing and Addressing the Military System—Public Health Implications of Trauma & Violence

- **(T)** Kraft: pp. 114-149
- **(T)** Rothschild: Introduction-Chapter 4
- **(B)** Bloom, S. L. (1996). Every time history repeats itself, the price goes up: The social reenactment of trauma. Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention, 3(3), 161-194.
- **(B)** Chu, J. A. (1991). The repetition compulsion revisited: Reliving dissociated trauma. Psychotherapy: Theory, Research, Practice, Training, 28(2), 327.

Week #5-Complex Trauma Part 1

- **(T)** Kraft: pp. 150-194
- **(T) Rothschild:** Chapters 5-8

- **(B)** Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. Psychological Trauma: Theory, Research, Practice, and Policy, S(1), 86-100.

Week #6-Complex Trauma Part 2

- **(T)** Kraft: pp. 195-228
- **(T) Rothschild:** Chapters 9-12
- **(B)** Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. Journal of traumatic stress, 18(5), 449-459.

Week #7-Shared Trauma for the Military Clinician

- **(T)** Kraft: 229-243
- **(T) Rothschild:** Chapters 13-16
- **(B)** Tosone, C., Nuttman-Shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. Clinical Social Work Journal, 40(2), 231-239.
- **(B)** Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician?. Professional Psychology: Research and Practice, 42(1), 79.
- **Turn in reflection papers (Assignment 2)**

Week #8- Mid-Term Examination

*****This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Week #9- Military Sexual Trauma—A Trauma Informed Care Approach for Military Veterans

- **(B)** Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. American Journal of Public Health, 97(12), 2160-2166.
- **(B)** Maguen, S., Cohen, B., Ren, L., Bosch, J., Kimerling, R., & Seal, K. (2012). Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with posttraumatic stress disorder. Women's Health Issues, 22(1), e61-e66.
- **(B)** Mattocks, K. M., Haskell, S. G., Krebs, E. E., Justice, A. C., Yano, E. M., & Brandt, C. (2012). Women at war: Understanding how women veterans cope with combat and military sexual trauma. Social science & medicine, 74(4), 537-545.

Week #10-Interpersonal Violence & the Military; Trauma Informed Care and Military Related IPV Survivors

- **(B)** Iverson, K. M., Wells, S. Y., Wiltsey-Stirman, S., Vaughn, R., & Gerber, M. R. (2013). VHA primary care providers' perspectives on screening female veterans for intimate partner violence: A preliminary assessment. *Journal of family violence*, *28*(8), 823-831.

- **(B)** Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: interpersonal violence, PTSD, and mental health in women veterans. *Research in nursing & health*, *34*(6), 457-467.

- **(B)** Marshall, A. D., Panuzio, J., & Taft, C. T. (2005). Intimate partner violence among military veterans and active duty servicemen. Clinical psychology review, 25(7), 862-876.

Week #11- Trauma Informed Care for Homeless Veterans

- **(B)** Dinnen, S., Kane, V., & Cook, J. M. (2014). Trauma-informed care: A paradigm shift needed for services with homeless veterans. *Professional case management*, *19*(4), 161-170.
- **(B)** Hamilton, A. B., Poza, I., & Washington, D. L. (2011). "Homelessness and trauma go hand-in-hand": Pathways to homelessness among women veterans. *Women's Health Issues*, *21*(4), S203-S209.
- **(B)** Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3(2), 80-100.

Week #12- Leadership for Change—Part 1

- **(B)** Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies, Incorporated.
- **(B)** Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education*, *52*(1), 18-29.

Week #13-Leadership for Change—Part 2 & Class Presentations

- **(B)** Sullivan, W. P. (2016). Leadership in Social Work: Where Are We?. *Journal of Social Work Education*, *52*(sup1), S51-S61.

- **(B)** Wolff, T., Minkler, M., Wolfe, S. M., Berkowitz, B., Bowen, L., Butterfoss, F. D., & Lee, K. S. (2016). Collaborating for equity and justice: Moving beyond collective impact. Nonprofit Quarterly, 23(4), 42-53.

Week # 14- Class Presentations & Course Wrap-Up

- **Final Assignment Due**

Chapter 11: Conclusion and Implications for Military Social Work Education

Implications & Evaluations

The initial course in the curriculum based dissertation, *Introduction to Military Culture and Social Work Practice*, has already been successfully taught and implemented at a Council on Social Work Education Accredited Institution of higher learning. The course was initially posted to the University's course catalog as a "selected topics" or elective course in the Fall 2016 semester. The course was then selected to be formally proposed to the University Senate Committee on Curricula (SCC) for regularization.

The rationale for its selection for course regularization was that it serves as an elective in the BSSW and MSW program to provide foundational information on military culture and Veterans as consumers. Enhancing practitioner knowledge of these matters is congruent with both the priorities of the social work profession and the strategic plan of the university. The course supports program learning objectives through support of the seven foundational competencies of the BSSW and MSW programs: Demonstrate ethical and professional; engage diversity and difference in practice; Advance human rights, and social, economic, and environmental justice; Engage in policy practice; Engage with Individuals, families, groups, organizations, and communities; Assess individuals, families, groups, organizations and communities; Intervene with individuals, families, groups, organizations, and communities.

The following illustrations represent student course evaluations for the initial course in the proposed military graduate certificate program. The evaluations below reflect the course being taught during the fall 2016 term in a School of Social work at a CSWE accredited university. The course was cross-listed, allowing both undergraduate and graduate students to enroll in the course.

Illustration: 5

Illustration 5 provides a breakdown of enrollment status, major/degree program, and class status for the *Introduction to Military Culture and Social Work Practice* course offered during the Fall 2016 semester at a School of Social Work. The overall response rate for the end of year evaluations was 75.0%. The course consisted of both undergraduate and graduate students.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

1. Enrollment status:	N	%
Full-time Matriculated	4	80.0%
Part-time Matriculated	1	20.0%
Part-time Non-matriculated	0	0.0%
Total	5	

2. Major/Degree Program:	N	%
Social Work	5	100.0%
Other	0	0.0%
Total	5	

3. Class Status:	N	%
Freshman	0	0.0%
Sophomore	1	20.0%
Junior	0	0.0%
Senior	0	0.0%
Graduate	4	80.0%
Total	5	

Illustration: 6

Illustration 6 provides student feedback in the following areas: I gained an understanding of major concepts in this field; I learned to think critically about issues in this field; I found this class intellectually challenging; I learned how culture/human diversity intersects with the content of this course. Students were asked to respond anonymously on a scale from 1-5; ranging from strongly disagree to strongly agree. As demonstrated below in illustration 6, 100% of the

students selected Strongly Agree (5) to understanding all five topic areas listed in this section of the evaluation.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		Summary Stats		
	N	%	N	%	N	%	N	%	N	%	N	Mean	StD
4. I gained an understanding of major concepts in this field.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
5. I learned to think critically about issues in this field.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	100.0%	5	5.00	0.00
6. I found this class intellectually challenging.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
7. I learned how culture/human diversity intersects with the content of this course.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	100.0%	5	5.00	0.00
TOTAL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	22	100.0%	22	5.00	0.00

Illustration: 7

Illustration 7 highlights comments students provided directly on the anonymous course survey. The students were asked to comment on their specific experience as a learner in the course on military culture and social work practice.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

Comment on your experience as a learner in this course.

- As a learner I was challenged to think critically, and to analyze and link practice with theory.
- I absolutely loved this course. I learned about different ethical dilemmas one may face as a social worker, in the military or not. This class has encouraged me to continue my education to become a Social Worker.
- I learned a significant amount not only through instruction and course content, but by student participation and group discussion.
- This class was amazing Ken really was able to give real world examples of military social work and the complexities within that role. Ken also was able to give us indepth knowledge of culture with in the military and its important role when working with these clients. I think that the course can be imporved by adding projects with more contact with the entended population. More courses on military social work sould be offered.
- This course offered a wide range of information about working directly with veteran and military populations. Coming from a former military service member, the course was invaluable to a critical area of social work that has long been overlooked by schools of social work. Though I am interested in the population of veterans and active duty service members on a personal level, this course offered insights to working with the population that I had not previously considered and allowed me to frame my previous understandings in ethical clinical perspectives.

Illustration: 8

Illustration 8 provides student feedback in the following areas: The instructor communicated course purposes and objectives clearly; The instructor seemed well prepared for each class; The instructor appeared to have a thorough knowledge of the subject; The instructor used class time effectively. Students were asked to respond anonymously on a scale from 1-5; ranging from strongly disagree to strongly agree. As demonstrated below in illustration 8, 100% of the students selected Strongly Agree (5) to understanding all four topic areas listed in this section of the evaluation. Of particular note, the introductory course listed in this dissertation was utilized, to include all required texts, readings, and assignments. The syllabus carefully outlines course purposes, objectives, and appropriately assists the instructor for adequate preparation for class sessions.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		Summary Stats		
	N	%	N	%	N	%	N	%	N	%	N	Mean	StD
9. The instructor communicated course purposes and objectives clearly.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
10. The instructor seemed well prepared for each class.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
11. The instructor appeared to have a thorough knowledge of the subject.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
12. The instructor used class time effectively.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
TOTAL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	24	100.0%	24	5.00	0.00

Illustration 9

Illustration 9 examines the following areas: The instructor clearly communicated the subject matter of the course, including concepts, content and issues; The instructor's style of presentation held my interest; The Instructor seemed concerned about whether students learned the material. As seen below, 100% of the students selected Strongly Agree (5) to understanding all three topic areas listed in this section of the evaluation. This area highlights the importance of student engagement through presentation style(s). The syllabus is explicit in placing an emphasis on student engagement through reading leadership, small group discussions, guest lectures, case vignettes, large group discussions, and student presentations. This multifaceted approach allows students of diverse backgrounds and various learning styles to be actively engaged in the learning process, promoting an intellectually stimulating learning environmnet, ultimately fostering growth in the field of military social work.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		Summary Stats		
	N	%	N	%	N	%	N	%	N	%	N	Mean	StD
13. The instructor clearly communicated the subject matter of the course, including concepts, content and issues.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	100.0%	4	5.00	0.00
14. The instructor's style of presentation held my interest.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	100.0%	4	5.00	0.00
15. The instructor seemed concerned about whether students learned the material.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	100.0%	4	5.00	0.00
TOTAL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	100.0%	12	5.00	0.00

Illustration: 10

Illustration 10 focuses on student evaluations related to the importance of continuous feedback regarding their individual performance, and ensuring all assignments are clearly defined. Mandatory assignments and course requirements are appropriately outlined in the course syllabus within this dissertation. The class syllabus and assignments are also reviewed during session 1 of the course. In addition, the syllabus is continually reviewed throughout the course to ensure all members of the learning environment are aware of their weekly requirements.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		Summary Stats		
	N	%	N	%	N	%	N	%	N	%	N	Mean	StD
21. The instructor provided useful feedback to students regarding their learning and performance.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
22. Assignments for the course were clearly explained.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
TOTAL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	100.0%	12	5.00	0.00

Illustration: 11

Illustration 11 evaluated the integration of assigned readings with course topics and the pace at which the material is presented. The syllabus is crafted in a way that allows students to reflect on the appropriate week's reading, while integrating their individual learning into class discussions and individual lectures. The below illustration indicates that 100% of students completing the evaluation "strongly agree" that the assigned readings were well integrated and the material was presented at an appropriate pace.

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		Summary Stats		
	N	%	N	%	N	%	N	%	N	%	N	Mean	StD
23. The assigned readings were well integrated with course topics.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
24. The instructor presented the material at an appropriate pace.	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	100.0%	6	5.00	0.00
TOTAL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	100.0%	12	5.00	0.00

Illustration: 12-14

The following illustrations (12-14) focused on strengths, weaknesses, and suggestions for improving course related performance. As seen below, students comments indicated that there is a need for more military related course content within the field of social work, to include content for both undergraduate and graduate students. In addition, students highlighted that they wanted more materials and there was simply not enough time to cover all the material within one semester.

Illustration: 12

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

Please describe briefly some of the major strengths of this instructor's course-related performance:

- As a member of the population discussed and a clinician who has worked with service members throughout his career, the professor was more than knowledgeable about the course material. He was able to facilitate classes in a way that encourage deeper-level thinking and constructive discussions about the course topics. he was able to provide insights into working with veterans and service members that have improved my confidence in feeling that I will be able to work with the population in the future.
- Ken was GREAT! Ken really provided a safe place for students to feel comfortable to really engage in discussion and class. Ken is able to provide examples from his experience in the past and his current practice. Ken should be a full time professor.
- Professor Ken was a effective communicator and resourceful iin providing information.
- Professor Marfilius is a phenomenal teacher. He presents each topic in an interesting manner and encourages equal participation from his students. He is a great role model for those who are interested in the field of social work, or any helping profession. I recommend this course/instructor to everyone in the social work program at SU.
- The course topics and assignments were of interest to the class and were tailored to our questions and discussions throughout each session.
- The information presented was relevant, professionally presented, The use of technology was appropriate. The class was very interactive and no one seemed pressured to respond. There was also a high level of maturity and respect among the class members and I believe that Prof. Marfillius brought this to his his class because he led by example.

Illustration: 13

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

Please describe briefly some of the major weaknesses/shortcomings of this instructor's course-related performance:

- Because the curriculum is titled as an "into" level course, I regret not being able to explore some topics in more depth. I am left with big questions about what it means to work with military populations both as a social worker, and in regards to the relationship with unique DoD poicy and UCMJ codes.
- I cannot think of anything
- (2) None
- There weren't enough weeks to cover all of the coursework of interest.
- This class was perfect.

Illustration: 14

Department: Social Work
Term: Fall 2016
Form: Social Work Course Evaluation
Instructor: Marfilius,Kenneth James
CROSS-LISTED: Marfilius,Kenneth James SWK400 M001 and SWK600 M001
Responses: 6 Enrollment: 8 Response Rate: 75.0%

Please describe briefly any suggestions for improving this instructor's course-related performance:

- Add more in class case studies where the students can practice being a military Social Worker. We had some, more may be added.
- I think more undergraduate social work students should have the opportunity to take this course. I truly learned more in this one semester than I have my entire undergrad. I had a wonderful experience in Professor Marfilius' class and believe I will be a better social worker/person because of the lessons learned.
- Professor Ken is very knowledgeable on military culture and was able to effectively communicate the culture in a way where students will be able to understand.It was easy to apply the knowledge in a social work context.
- Teach more classes.
- Teach part 2 of this class in the spring.
- This course was an ideal scenario of instructor-student involvement with course material. I would recommend the class to any social work student looking to take an elective, and especially to those who plan to work with military. My only suggestion is for the Falk School of Social Work to take this class as an opportunity to be a national trendsetter in military-informed social work practice, a growing and necessary field in the area of social work.

Future Directions

Social Work schools are uniquely situated for the continued development of clinically driven certificate programs solely focused on serving our nation's military service members, Veterans, and their families. Many universities have long-standing histories serving this population in various capacities, specifically offering support to transitioning service members and their families through utilization of the GI Bill. The military social work course content would fill a much needed gap in properly training civilian mental health providers to develop basic military cultural and clinical competence in order to address the unique psychosocial issues specific to this population.

Cohort Model

The military social work certificate program has been designed to offer specialized training for students interested in providing care for active duty military, Veterans, and their families. In addition to course content, the certificate program would create a unique cohort model. The cohort model would include students who have applied and been accepted in the military certificate program. This approach is designed to build student cohesion, teamwork, and peer support, a model that aligns closely with military culture. The program would also include placing students in the appropriate field placement where they would obtain maximum benefit from working with military populations. The military social work certificate program courses are designed to fulfill the requirements of the MSW program; therefore, allowing the student to simultaneously earn the certificate and complete their MSW coursework without disruption.

Field Placements

Institutions of higher learning not only serve Veterans in academia but are often closely linked with VA hospitals, Vet centers, community agencies serving military populations, ROTC

detachments, and active duty or reserve military installations. Social workers are employed at many of the previously listed agencies and serve as primary healthcare professionals. MSW students who have been accepted into the certificate program would be placed at one of the many agencies serving military service members, Veterans, or their families. The military social work program director would be the primary field liaison for the military social work cohort and maintain a clear line of communication with both the student and the preceptor. The program director is to meet individually with the student and the preceptor at the field site and ensure the student is gaining maximum benefit from their field placement experience and addressing any concerns that may arise.

An Interdisciplinary Approach

Schools of Social Work have the unique opportunity to establish the certificate program and work collaboratively with many of departments and disciplines represented across the institution of higher learning. An interdisciplinary approach would not only enhance the student's experience; however, allow the other departments to join forces in serving this population. The opportunities to collaborate and offer courses or professional lectures across departments and disciplines are seemingly endless. For example, military service members and Veterans who are under the care of a social worker find themselves involved in the legal system. The Social Work Department could work in partnership with the College of Law to discuss the Uniform Code of Military Justice (UCMJ) and the overall effects on the service member. The UCMJ is a congressional code of military criminal law applicable to all military members serving worldwide and its effects are far-reaching. Military law and the commander have a significant influence on the service member's future, ultimately impacting their access to medical care, financial incentives, educational opportunities, and various other programs. Military law and the

commander have ultimate power and make the final decision on the level of discharge for each service member. The level of discharge determines whether or not a Veteran has access to the VA system or service connected disability. The Judicial System recognizes the number of Veterans in the civilian legal and criminal system. In recent years, the Veterans treatment court has been a growing trend, tending to the unique demands our Veterans are faced with on a daily basis. This has opened up unique positions for social workers to serve within the VA system; such as, Veteran Justice Outreach workers. In addition to the previously stated examples, there are many other departments and disciplines that could benefit from the certificate program; such as, Psychology, Education, Psychiatry, and University counseling center's that may be seeing an increased number of Veterans utilizing their services.

Immersion and Guest Speakers

While field placements would expand the knowledge base and skill set of the military social work cohort, the program would also involve the cohort visiting many of the agencies directly serving this population. These mini immersions would allow the students to engage with fully licensed providers who are currently serving the population. It would also afford the students an opportunity to get out of the classroom and immerse themselves in a real world environment. Potential guest speakers could include retired military personnel (officer and enlisted), military/veteran mental health clinicians, or family members who have sacrificed and dedicated their lives to the mission. While aiming to take an interdisciplinary approach, students can attend lectures and courses outside the Social Work department to broaden their knowledge. The Social Work department could also play host to many academics and additional students who may have interest in serving this population in another capacity; however, gain significant benefit from attending one of the courses offered in the military social work certificate program.

Appendix (A)

CSWE Advanced Social Work Practice in Military Social Work

<table>
<tr><td colspan="2">Advanced Social Work Practice in Military Social Work</td></tr>
<tr><td colspan="2">Educational Policy 2.1.1- Identify as a professional Social worker and conduct oneself accordingly</td></tr>
<tr><td>Selected Practice Behaviors</td><td>Military Social Work Knowledge and Practice Behaviors</td></tr>
<tr><td>• Advocate for client access to the services of social work
• Practice personal reflection and self-correction to assure continual professional development
• Attend to professional roles and boundaries
• Demonstrate professional demeanor in behavior, appearance, and communication
• Engage in career-long learning
• Use supervision and consultation</td><td>• Engage in lifelong learning, supervision, and consultation to enhance knowledge and skills needed to work effectively with service members, veterans, their families, and their communities
• Practice self-reflection and continue to address personal biases and stereotypes to build knowledge and dispel myths regarding service members, veterans, their families, and their communities
• Demonstrate professional demeanor that reflects awareness of and respect for military and veteran cultures
• Recognize boundary and integration issues between military and veteran cultures and social work values and ethics</td></tr>
<tr><td colspan="2">Educational Policy 2.1.2—Apply social work ethical principles to guide professional practice</td></tr>
<tr><td>Selected Practice Behaviors</td><td>Military Social Work Knowledge and Practice Behaviors</td></tr>
<tr><td>• Adhere to the standards of licenses or credentials
• Recognize and manage personal values in a way that allows professional values to guide practice
• Make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics (1999) and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles (2004)
• Tolerate ambiguity in resolving ethical conflicts
• Apply strategies of ethical reasoning to arrive at principled decisions</td><td>• Employ strategies of ethical reasoning in an environment that may have policy and value conflicts with social work service delivery, personal values, and professional ethics
• Identify the military culture’s emphasis on mission readiness, support of service, honor, and cohesion and how it influences social work service delivery at the micro, mezzo, and macro levels
• Recognize and manage appropriate professional boundaries within the military and veteran context</td></tr>
</table>

Educational Policy: 2.1.3. Apply critical thinking to inform and communicate professional judgments	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Distinguish, appraise, and integrate multiple sources of knowledge, including research based knowledge and practice wisdom • Analyze models of assessment, prevention, intervention, and evaluation • Demonstrate effective oral and written communication in working with individuals, families, groups, organizations, communities, and colleagues	• Analyze the unique relationships among the client, the family, the military, and various veterans' organizations • Use professional judgment to meet the needs of all involved clients • Analyze appropriate models of assessment, prevention, intervention, and evaluation within the context of military social work • Use appropriate practice models with service members, veterans, their families, and their communities • Demonstrate effective oral and written communication using established DoD/VA professional standards and practices
Educational Policy 2.1.4—Engage diversity and difference in practice	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power • Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups • [Social workers] recognize and communicate their understanding of the importance of difference in shaping life experiences • [Social workers] view themselves as learners and recognize clients as the experts	• Manage potential conflicts between diverse identities within and among individuals and the military and veterans' organizations • Manage potential conflicts between personal feelings/expression and collective/institutional responsibility • Recognize the potential risk and protective factors among diverse populations and communities that may be the result of military service • Communicate with a culturally responsive approach that includes service members with varying statuses including active duty/ retired, guard/reserves, combat/garrison, and so forth
Educational Policy 2.1.5—Advance human rights and social and economic justice	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Understand the forms and mechanisms of oppression and discrimination Advocate	• Identify and analyze conflictual responses and potential consequences to conflicts

for human rights and social and economic justice • Engage in practices that advance social and economic justice	between basic human rights and military life and duty experience • Advocate at multiple levels for service parity and reduction of service disparities for the diverse service member populations • Identify the needs of military and veteran individuals, families, and communities to civilian providers and workplace management • Teach skills to promote self-sufficiency, self-advocacy, and empowerment within the context of practice and culture
Educational Policy 2.1.6—Engage in research-informed practice and practice informed research	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Use practice experience to inform scientific inquiry • Use research evidence to inform practice	• Locate, evaluate, and analyze current research literature related to military social work • Evaluate research to practice with service members, veterans, families, and their communities • Analyze models of assessment, prevention, intervention, and evaluation within the context of military social work • Apply different literature and evidence informed and evidence-based practices in the provision of services across the DoD/ VA continuum of care and services
Educational Policy 2.1.7—Apply knowledge of human behavior and the social environment	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Use conceptual frameworks to guide the processes of assessment, intervention, and evaluation • Critique and apply knowledge to understand person and environment	• Recognize and assess social support systems and socioeconomic resources specific to service members, veterans, their families, and their communities • Recognize the impact of military transitions and stressful life events throughout the family's life course • Identify issues related to losses, stressors, changes, and transitions over the life cycle of service members, veterans, their families, and their communities in designing interventions

	• Demonstrate the ability to critically appraise the impact of the social environment on the overall well-being of service members, veterans, their families, and their communities
Educational Policy 2.1.8—Engage in policy practice to advance social and economic well-being and to deliver effective social work services	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Analyze, formulate, and advocate for policies that advance social well-being • Collaborate with colleagues and clients for effective policy action	• Communicate effectively with various veterans' service organizations to provide effective social work services and accurate benefits, entitlements, and services information to clients, their family members, and their communities • Apply knowledge of the Uniform Code of Military Justice • Use social policy analysis as a basis for action and advocacy with the chain of command and within federal agencies • Respond to civilian and governmental inquiries (e.g., congressional inquiry)
Educational Policy 2.1.9-Respond to contexts that shape practice	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services • Provide leadership in promoting sustainable changes in service delivery and practice to improve the quality of social services	• Assess service systems' history, trends, and innovations in social work practice with service members, veterans, their families, and/or their communities • Apply knowledge of practice within the military context to the development of evaluations, prevention plans, and treatment strategies • Use information technologies and organizational analysis techniques for outreach, planning multiyear projections, for service delivery to service members and the veteran populations as well as to their families and their communities

Educational Policy 2.1.10(a)–(d)—Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities	
Educational Policy 2.1.10(a)—Engagement	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors
• Substantively and effectively prepare for engagement with individuals, families, groups, organizations, and communities • Use empathy and other interpersonal skills • Involve the client in goal-setting, focus of work, and desired outcomes	• Recognize the unique issues and culture presented by the service member, veteran, and/or family member client • Establish a culturally responsive therapeutic relationship that addresses the unique issues associated with confidentiality and reporting requirements within a military context • Explain the nature, limits, rights, and responsibilities of the client who seeks services • Explain the stigma, risks, and benefits of seeking or not seeking services • Engage with military leadership, the unit, veteran service organizations, and/or family members • Demonstrate a knowledge base related to risk and protective factors associated with deployment, military service, and other aspects of life and role transitions that service members and veterans experience • Demonstrate knowledge related to health and mental health illnesses, injuries, and outcomes for service members, veterans, their families and their communities
Educational Policy 2.1.10(b)—Assessment	
Selected Practice Behaviors	Military Social Work Knowledge and Practice Behaviors

• Collect, organize, and interpret client data • Assess client strengths and limitations • Develop intervention goals and objectives • Select appropriate intervention strategies	• Select and modify appropriate multisystemic intervention strategies based on continuous clinical assessment of military or veteran issues • Use differential and multiaxial diagnoses that take into consideration signature injuries as well as other military related illnesses and injuries • Use empathy, cultural responsiveness, and other interpersonal skills in completing an assessment • Assess coping strategies to reinforce and improve adaptation to life situations and transitions while also emphasizing ways of coping with readjustment from military to civilian life
Educational Policy 2.1.10(c)—Intervention	
• Initiate actions to achieve client and/or organizational goals and resolve problems • Implement prevention interventions that enhance client capacities • Negotiate, mediate, and advocate for clients • Facilitate transitions and endings	• Use a range of appropriate clinical and preventive interventions for various injuries, diagnoses, and psychosocial concerns identified in the assessment, including crisis intervention and advocacy strategies as needed • Engage clients in ongoing monitoring and evaluation of practice processes and outcomes • Demonstrate the capacity to reflect on one's own responses (e.g., affect and world views) that influence the progress in and the completion of treatment
Educational Policy 2.1.10(d)—Evaluation	
• Critically analyze, monitor, and evaluate interventions	• Use clinical and program evaluation of the process and/or outcomes to develop best practice interventions and programs for a range of bio-psycho-social-spiritual conditions • Evaluate practice to determine the effectiveness of the applied intervention on military/veteran issues

Appendix (B)

Course Syllabus
Master of Social Work Program
Introduction to Military Culture and Social Work Practice

Instructor	Ken Marfilius, MSW, LCSW	Phone	TBA
Office	TBA	E-mail	TBA
Office Hours	By Appointment	Class Time	

Prerequisite/Co-requisite: None

AUDIENCE

This course is designed for graduate students interested in gaining knowledge of military culture and advancing skills in the field of military social work.

COURSE DESCRIPTION

Introduction to military culture and social work practice with military service members, veterans, and their families. Designed to assist students in understanding military culture and to provide clinically and culturally competent services to military populations.

ADDITIONAL COURSE DESCRIPTION

The course will include a brief history of social work practice with military service members, veterans, and their families. Students will gain an understanding of the unique demands of the military and its influence on the service member and the social worker. It will entail a thorough review of command structure, the NASW code of ethics, and ethical dilemmas social workers encounter when working in a military environment. The course will examine the many complex aspects of trauma and available evidence based treatment modalities. In addition, the course will highlight the effects of trauma on the entire family unit, impacting children and spouses. The role of psychological stigma, systemic, and organizational barriers to care will be explored. The course will focus on the social workers role in assisting the service member with reintegration back into the civilian sector and access to VA care.

Credits: 3 Credit Units

LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Demonstrate a basic understanding of military culture, command structure, and its impact on psychosocial health

2. Distinguish the difference between social work practice in the active duty and veteran settings
3. Demonstrate a comprehensive understanding of the NASW code of ethics and how to properly address ethical dilemmas in the military environment
4. Recognize the military as the dominant paradigm and how this may lead to confidentiality/privacy issues, dual loyalty conflicts, and secondary trauma
5. Utilize evidence based treatment modalities grounded in empirical research and supported by the Veteran's Affairs administration to aid in providing the best possible trauma therapy and crisis interventions for military members, veterans, and their families
6. Explain how to build resilience in military families, care for bereaved family members, and address the overall health consequences of military service and combat
7. Identify the various psychological, systemic, and organizational barriers to care for military members and their families

Bibliography/ Texts / Supplies – Required:

Marlantes, K. (2011). *What it is like to go to war*. Grove/Atlantic, Inc.

Rubin, A., Weiss, E. L., & Coll, J. E. (Eds.). (2012). *Handbook of military social work*. John Wiley & Sons.

REQUIREMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

CLASS ASSIGNMENTS

Class Attendance, Participation, & Discussion Leadership (10 pts): Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership. Missing more than 3 sessions will result in the student appearing before the Master's degree evaluation committee and may result in a permanent incomplete or failure of the course.

Discussion Leadership: Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and military social work practice.

Learning Outcomes # 1-7

Assignment 1 (20 pts): Case Vignette/Ethical Decision Making in Military Social Work Students will be provided a case vignette and be required to answer discussion questions pertaining to their specific case example. Students will submit a 3-5 page paper utilizing models for ethical decision-making, make ethical decisions by applying the standards of the NASW Code of Ethics, and write on how they would use supervision and consultation to guide professional judgment and behavior.

Learning Outcomes: # 1, 3, 4, 7

Assignment 2 (30 pts): Reflection Paper

Students will submit a 3-5 page reflection paper on *What It Is like to go to War* by Karl Marlantes, in regards to military training, culture, combat, and its implications for social work practice. The following are some questions to guide you when you write: Do you believe this book served as a therapeutic tool for the author? What themes emerged to you as the reader? What did it make you realize or rethink about military culture and implications for social work practice? Marlantes "needed desperately to be accepted back in" (p.184), how can the social worker assist in the meaning making process and reintegration back into the civilian sector? What are some of the health consequences that emerge as a result of military service and combat? Professional social workers have been working as uniformed members of the military since WWII, what are some ethical challenges the social worker may experience in the deployed setting?

Learning Outcomes: # 1, 4, 6, 7

Assignment 3 (40 points): Military Service Interview and Presentation

Paper (30 points)
Presentation (10 points)

Students must select a current active duty service member or veteran to interview. The instructor will assist students in identifying a service member or veteran on an as needed basis. Students must select their interviewee prior to session 6 of this course. Students must get approval from the instructor and have the interviewee sign a release form. Please utilize the questions below as an interview guide. This guide is not meant to be exhaustive, and some questions may not apply to your interviewee. This is meant to be an interview guide to aid in developing a framework for your paper and presentation.

Papers should be between 7-8 pages, double-spaced, 12 point font, Times New Roman, and APA format. Students will also conduct a 15-20 minute class presentation developed from their interview, integrating course content. The presentation can be in any format. Power points, verbally from a script, and videos are all acceptable formats.

Interview Guide

Students should explain the nature of the interview and its use.

1) Identify all demographic characteristics; such as, branch of service, military occupation, rank, age at service entry, age at separation/retirement, status (active duty, reserve, veteran), race, gender, ethnicity.
2) Ask the interviewee their status prior to entering military service.
    a. Educational status, occupational status, financial status, home of record, religion, family life, belief systems, values, and traditions
    b. Keep in mind any predisposing factors or vulnerabilities present prior to service
3) Why did the interviewee choose to enter military service?
4) What military installation(s) was the interviewee stationed at throughout their time of service? Were they stationed overseas? Was the interviewee ever deployed? If so, what was their experience of the deployment? How did the mission or culture change at each installation?
5) Ask the interviewee if/how their personal traditions, core belief system, values, and culture has changed from the time they entered the military and throughout the course of their career. Was this a positive or negative impact on their personal life?
6) What was/is the impact on the service member or veteran's family unit? Does the interviewee feel that there was a positive or negative relationship between the military mission and their family life? Ask the interviewee about their children and spouses. For example, did the interviewee's children attend Department of Defense schools, installation youth centers, daycare, etc.? Was the spouse employed during military service?
    a. For this section, if possible, ask the interviewee if you could briefly interview their spouse or children about their experiences with military lifestyle and culture.
7) What has the transition(s) been like for the interviewee? If the member is still actively serving, what are the challenges they face from moving often, overseas, or short term tours without their family? If the interviewee is a veteran, ask them to describe their transition and reintegration back into the civilian sector. What are some of the challenges they faced throughout the transitioning process? Do they have experience with the VA system or other community based agencies serving veterans? Have they utilized the Montgomery or Post 9/11 GI Bill, VA home loans, or other transitional options available to veterans?
8) Discuss your experience while interviewing the service member or veteran. What was the experience like for you? How did the interview enhance your learning about military culture and aid in understanding to enhance your social work practice with service members, veterans, and their families?

Learning Outcomes: # 1, 2, 4, 6, 7

Grading:

Class Participation:	10 pts
Assignment One:	20 pts
Assignment Two:	30 pts
Assignment Three:	40 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers

Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Academic Integrity Policy

It is a mandatory requirement that all students reflect the highest value placed on honesty in academic work. It is the student's responsibility to learn about course and university expectations regarding academic integrity. Cheating or plagiarism of any kind will not be tolerated.

Weekly Course Topics and Readings

T=Located in course required textbook(s)
B=Located on blackboard

Week #1- Course Introduction & the Culture of Military Life

- **(T)** Rubin Weiss & Coll: Chapter 2
- **(T)** Marlantes: Chapters 1, 2

- **(B)** Petrovich, J. (2012). Culturally competent social work practice with veterans: An overview of the US Military. *Journal of human behavior in the social environment*, *22*(7), 863-874.

Week #2- History of Social Work with Service Members, Veterans, & their Families

- **(T)** Rubin Weiss & Coll: Chapter 1 & 18
- **(T)** Marlantes: Chapters 3, 4
- **(B)** Savitsky, L., Illingworth, M., & DuLaney, M. (2009). Civilian social work: Serving the military and veteran populations. *Social Work*, *54*(4), 327-339.

Week #3- Military Social Work Ethics Part 1

- **(T)** Rubin Weiss & Coll: Chapter 4
- **(T)** Marlantes: Chapters 5, 6
- **(B)** Simmons, C. A., & Rycraft, J. R. (2010). Ethical challenges of military social workers serving in a combat zone. *Social work*, *55*(1), 9-18.
-

Week #4-Military Social Work Ethics Part 2

- **(B)** Johnson, W. B., Grasso, I., & Maslowski, K. (2010). Conflicts between ethics and law for military mental health providers. *Military medicine*, *175*(8), 548-553.
- **Assignment 1 Due:** Ethical Decision Making in Military Social Work/Case Vignette Paper & Class Discussions

Week #5-Military Crisis Intervention

- **(T)** Rubin, Weiss & Coll: Chapter 14
- **(T)** Marlantes: Chapters 7, 8
- **(B)** Bryan, C. J., Jennings, K. W., Jobes, D. A., & Bradley, J. C. (2012). Understanding and preventing military suicide. *Archives of Suicide Research*, *16*(2), 95-110.
- **(B)** VA Pocket Guide/Suicide
- View documentary on *Veterans Press 1*

Week #6-Preventing, Assessing, and Treating Substance Use Disorders in Military Populations

- **(T)** Rubin, Weiss, & Coll: Chapters 12, 13
- **(T)** Marlantes: Chapters 9, 11
- **(B)** VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders

Week #7-Domestic Violence in the Military

- **(T)** Rubin, Weiss & Coll: pp. 11-13, 306, 324-328

- **(B)** Marshall, A. D., Panuzio, J., & Taft, C. T. (2005). Intimate partner violence among military veterans and active duty servicemen. *Clinical psychology review*, *25*(7), 862-876.
- **(B)** Review worksheet prior to class: Principle Elements of Strategic Plan for More Effectively Addressing Domestic Violence Matters within the DoD

Week #8- Building Resilience in Military Personnel

- **(B)** Whealin, J. M., Ruzek, J. I., & Vega, E. M. (2013). Cognitive behavioral methods for building resilience.
- **(B)** Bartone, P. T. (2006). Resilience under military operational stress: can leaders influence hardiness?. *Military Psychology*, *18*(S), S131.
- **(B)** Britt, T. W., & Oliver, K. K. (2013). Morale and cohesion as contributors to resilience.
- **Assignment 2 Due:** Reflection Paper

Week #9- PTSD & Evidence Based Treatments

- **(B)** Sharpless, B. A., & Barber, J. P. (2011). A clinician's guide to PTSD treatments for returning veterans. *Professional Psychology: Research and Practice*, *42*(1), 8.
- **(B)** Keane, T. M., Niles, B. L., Otis, J. D., & Quinn, S. J. (2011). Addressing posttraumatic stress disorder in veterans: The challenge of supporting mental health following military discharge.
- View 60 Minutes Video-Advanced PTSD Therapy

Week #10-Military Families Impacted by Military Service

- **(T)** Rubin, Weiss, & Coll: Chapters 19, 22, 24, 26
- **(B)** Palmer, C. (2008). A theory of risk and resilience factors in military families. *Military Psychology*, *20*(3), 205.

Week #11- Women Service Members & Veterans/Military Sexual Trauma

- **(T)** Rubin, Weiss, & Coll: Chapter 3
- **(B)** Conard, P. L., Young, C., Hogan, L., & Armstrong, M. L. (2014). Encountering women veterans with military sexual trauma. *Perspectives in psychiatric care*, *50*(4), 280-286.
- **Film-** The Invisible War

Week #12- Veteran Social Work, Reintegration, & Transitional Care

- **(T)** Rubin, Weiss, & Coll: Chapters 15-17 (pp. 247-281)
- **(B)** Wheeler, D. P., & Bragin, M. (2007). Bringing it all back home: Social work and the challenge of returning veterans. *Health & Social Work*, *32*(4), 297-300.

Week #13-Addressing Secondary Trauma, Provider Burnout, & Self- Care for Military Social Workers

- **(T)** Rubin, Weiss, & Coll: Chapter 5
- **(B)** Lester, P. B., Taylor, L. C., Hawkins, S. A., & Landry, L. (2015). Current Directions in Military Health-care Provider Resilience. *Current psychiatry reports*, *17*(2), 1-7.
- **(B)** Linnerooth, P. J., Mrdjenovich, A. J., & Moore, B. A. (2011). Professional burnout in clinical military psychologists: Recommendations before, during, and after deployment. *Professional Psychology: Research and Practice*, *42*(1), 87.
- **(B)** Harrington, D., Bean, N., Pintello, D., & Mathews, D. (2001). Job satisfaction and burnout: Predictors of intentions to leave a job in a military setting. *Administration in Social Work*, *25*(3), 1-16.

Week # 14- Class Presentations & Course Wrap-Up

- **Assignment #3 Due**

Appendix (C)

Course Syllabus
Master of Social Work Program
Advanced Clinical Mental Health Practice with Military Service Members, Veterans, and their Families

Instructor	Ken Marfilius, MSW, LCSW	Phone	TBA
Office	TBA	E-mail	TBA
Office Hours	By Appointment	Class Time	

Prerequisite/Co-requisite: None

I. AUDIENCE

This course is designed for graduate students interested in gaining knowledge of evidence based practices and advancing clinical skills in the field of military mental health practice.

II. COURSE DESCRIPTION

Advanced clinical mental health practice with military service members, veterans, and their families. Designed to assist students in learning advanced clinical skills and methods necessary for working with diverse military populations.

III. ADDITIONAL COURSE DESCRIPTION

The course emphasizes the professional use of self, and critically examines evidence based practice modalities, specifically examining diversity and the cultural implications in practice. Students will learn principles and application of Cognitive Behavioral Therapy (CBT), Prolonged Exposure Therapy (PE), group treatment approaches, and additional evidence based treatment modalities and clinical practice with military families. The course will include content and dialogue on clinical and cultural competence when serving a diverse population within our nation's military. Class sessions will build on knowledge from other courses within the program and integrate experiences from field placements, case conceptualizations, and feedback from peers and instructor.

IV. LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Demonstrate and evaluate the professional use of self-perspective in clinical practice across multiple systems with military populations, while identifying and making appropriate use of clinical consultation and supervision, to further the development of a professional identity

2. Demonstrate advanced clinical knowledge of multiple evidence based treatment modalities when working with military service members, veterans, and their families
3. Appropriately uphold and apply the values and ethics of the social work profession to clinical practice situations across multiple systems
4. Apply critical thinking skills and evaluate research findings, agencies, and community practices, to develop and effectively implement evidence informed approaches to military social work interventions.
5. Distinguish their personal values in relation to the national association of social workers code of ethics, specifically the values of self-determination and diversity which illustrates and shapes the military service members, veterans, and military families human experience

V. REQUIREMENTS

A. Bibliography/ Texts / Supplies – Required:

Castner, B. (2013). The long walk: A story of war and the life that follows. Anchor Books.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged Exposure Therapy for PTSD: Therapist Guide: Emotional Processing of Traumatic Experiences*. Oxford University Press

Other Required Reading:

Required journal articles or chapters ***not in*** the required books above are accessible via

Blackboard.

VI. CLASS ASSIGNMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

Class Attendance, Participation, & Discussion Leadership:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership.

Assignment 1

Part 1 (10 Points) Blackboard Discussion:
Your class participation through blackboard discussion and reading leadership will be essential to the learning process. These activities are a class requirement and will contribute to your final grade. Students are required to create an original post in response to the appropriate week's readings and engage in commenting on your classmates posts.

Learning Outcomes # 1, 2, 3, 4, 5

Part 2 Reading Leadership (10 Points):

Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading(s) for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and advanced clinical practice with military populations.
Learning Outcomes # 1, 2, 3, 4, 5

Assignment 2 (20 pts): Journal Entries and Reflection Paper

Students will be required to maintain an active journal entry for each weeks assigned reading for the following text: *The long walk: A story of war and the life that follows.* Each journal entry should be no more than one page double spaced. Journal entries should include critical thought on how the content relates to advanced clinical mental health practice with military populations. Entries should include but not limited to the following themes: military culture, mental health practice, possible clinical approaches or interventions, the effect on the military family, transitioning back to the civilian sector, guilt, isolation, values, and ethics.
There should be a total of five journal entries and a 1-2 page reflection at the conclusion of the journal entries. The assignment is due at session 6 and should be no more than seven pages. Students will be expected to share their journal entries and reflection of the literature during session 6 of the course.

Learning Outcomes: # 1, 3, 5

Assignment 3 (30 pts): Midterm Exam in Class #8

This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Learning Outcomes: # 1, 2, 3, 4, 5

Assignment 4 (30 points): Final Paper and Presentation

Final Paper (20 points)

Presentation (10 points)

Students will be provided a case study by week 10. Please utilize the topics below as a guide for your case formulation paper and presentation. This is meant to be a guide to aid in developing a framework for your paper and presentation.

Papers should be between 5-7 pages, double-spaced, 12-point font, Times New Roman, and APA format. Students will also conduct a 15-20 minute class presentation developed from their interview, integrating course content. The presentation can be in any format. Power points, verbally from a script, and videos are all acceptable formats.

Case Formulation Guide

1) Given the provided case information, how would you work to develop a therapeutic relationship with the client? Integrate the literature on professional use of self (See week 1 readings).

2) Identify how you would make appropriate use of clinical consultation and supervision regarding the presented case study.

3) Highlight your personal values in relation to the NASW code of ethics, specifically the values of self-determination and diversity. Identify any potential cultural, social, and familial implications and how that may impact the therapeutic relationship, intervention, and overall treatment.

4) Identify a working or provisional diagnosis. Utilize the DSM 5 criteria to support your diagnosis. Do you view the diagnosis as a positive or negative in the healing process? Explain why.

5) Which intervention would you select for the client? Provide reasoning. For example, would you select CBT, PE, MI, group treatment, or an integration of multiple interventions, etc.

6) Introduce reasoning for selecting the intervention and share with your client. Provide research, background information, and how you would assist in educating your client about the selected intervention.

7) Would you refer any services out or elect to operate within a multidisciplinary approach? Explain why.

8) Identify potential roadblocks to treatment that you may anticipate. In addition, identify your assumptions, any countertransference, ethical, or legal dilemmas.

Learning Outcomes: # 1, 2, 3, 4, 5

Grading:

Assignment one
- Part 1 10 pts
- Part 2 10 pts

Assignment Two: 20 pts
Assignment Three: 30 pts
Assignment Four: 30 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers: Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Weekly Course Topics and Readings

T=Located in course required textbook(s)

B=Located on blackboard

Week #1- Professional Use of Self with Military Populations

- **(T)** Castner: Chapters 1-2
- **(B)** Arnd-Caddigan, M., & Pozzuto, R. (2008). Use of self in relational clinical social work. *Clinical Social Work Journal*, *36*(3), 235-243.
- **(B)** Dewane, C. J. (2006). Use of self: A primer revisited. *Clinical Social Work Journal*, *34*(4), 543-558.

Week #2- Evidence or Cultural Based Practice: A critical look

- **(T)** Castner: Chapter 2-4
- **(B)** Scandlyn, J. N. (2012). THE CANON-3: The harmony of illusions: Inventing post-traumatic stress disorder, by Allan Young. Anthropology & medicine, 19(1), 129-131.
- **(B)** Behrouzan, O. (2015). Medicalization as a way of life: The Iran-Iraq War and considerations for psychiatry and anthropology. Medicine Anthropology Theory, 2(3), 40-60.
- **(B)** Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health*, *8*(1), 34-45.

Week #3- Introduction to Cognitive Behavioral Therapy with Military Populations

- **(T)** Castner: Chapters 5-7
- **(B)** Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., ... & Wilkinson, E. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. *American journal of psychiatry*, *172*(5), 441-449.
- **(B)** van Doorn, K., McManus, F., & Yiend, J. (2012). An analysis of matching cognitive-behavior therapy techniques to learning styles. *Journal of Behavior Therapy and Experimental Psychiatry*, *43*, 1039-1044.

Week #4-Cognitive Behavioral Therapy Application

- **(T)** Castner: Chapters 8-9
- **(B)** Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual. Washington, DC: U.S. Department of Veterans Affairs.
    - Read pages 3-35

Week #5-Prolonged Exposure Therapy with Military Populations: An Introduction

- **(T)** Castner: Chapters 8-9
- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 1-2
- **Assignment 2 Due:** Journal Entries and Reflection Paper
  Paper and Class Discussions

Week #6-Prolonged Exposure Therapy: Sessions 1-3

- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 3-5
    - Review Trauma Interview: Appendix A

  Discussion of PTSD web based application

Week #7-Prolonged Exposure Therapy: Intermediate, Final Session, & Case Studies

- **(T)** Foa, E. B., Hembree, E. A., & Rothbaum, B. O.: Chapters 6-8
- **(B)** Tuerk, P. W., Yoder, M., Grubaugh, A., Myrick, H., Hamner, M., & Acierno, R. (2011). Prolonged exposure therapy for combat-related posttraumatic stress disorder: An examination of treatment effectiveness for veterans of the wars in Afghanistan and Iraq. *Journal of anxiety disorders*, *25*(3), 397-403.

Week #8- Mid-Term Examination

*****This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Week #9- Motivational Interviewing and Group Treatment

- **(B)** Britt, E., Hudson, S. M., & Blampied, N. M. (2004). Motivational interviewing in health settings: a review. *Patient education and counseling*, *53*(2), 147-155.
- **(B)** Hagedorn, W. B. & Hirshhorn, M. A. (2009). When talking won't work: Implementing experiential group activities with addicted clients. *The Journal for Specialists in Group Work, 34*(1), 43-67.
- **(B)** Resnicow, K., DiIorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational interviewing in health promotion: it sounds like something is changing. *Health Psychology, 21*(5), 444.
- **(B)** Sloan, D. M., Bovin, M. J., & Schnurr, P. P. (2012). Review of group treatment for PTSD. *Journal of Rehabilitation Research and Development*, *49*(5), 689-701.

Week #10-Veteran Affairs, Peer Support Services, and Group Treatment

- **(B)** Barber, J. A., Rosenheck, R. A., Armstrong, M., & Resnick, S. G. (2008). Monitoring the dissemination of peer support in the VA Healthcare System. *Community mental health journal*, *44*(6), 433-441.
- **(B)** Greden, J. F., Valenstein, M., Spinner, J., Blow, A., Gorman, L. A., Dalack, G. W., & Kees, M. (2010). Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. *Annals of the New York Academy of Sciences*, *1208*(1), 90-97.
- **Guest Presentation**

  *Final Assignment case study to be provided to students during session 10

Week #11- Housing First—An Evidence Based Practice to Ending Veteran Homelessness

- **(B)** Kertesz, S. G., Austin, E. L., Holmes, S. K., DeRussy, A. J., Van Deusen Lukas, C., & Pollio, D. E. (2017). Housing first on a large scale: Fidelity strengths and challenges in the VA's HUD-VASH program. *Psychological services*, *14*(2), 118.

- **(B)** Metraux, S., Cusack, M., Byrne, T. H., Hunt-Johnson, N., & True, G. (2017). Pathways into homelessness among post-9/11-era veterans. *Psychological services*, *14*(2), 229.
- **(B)** Tsai, J., O'toole, T., & Kearney, L. K. (2017). Homelessness as a public mental health and social problem: New knowledge and solutions. *Psychological services*, *14*(2), 113.
- **(B)** Tsemberis, S. (2010). *Housing first: The pathways model to end homelessness for people with mental illness and addiction manual*. Hazelden.

Week #12- The Military Family—Part 1

- **(B)** Asbury, E. T., & Martin, D. (2012). Military deployment and the spouse left behind. *The Family Journal*, *20*(1), 45-50.
- **(B)** Riggs, S. A., & Riggs, D. S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of Family Psychology*, *25*(5), 675.

Week #13-The Military Family—Part 2 & Class Presentations

- **(B)** Altshuler, J. L., & Ruble, D. N. (1989). Developmental changes in children's awareness of strategies for coping with uncontrollable stress. *Child development*, 1337-1349.
- **(B)** Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics*, *125*(1), 16-25.
- Make the Connection Video

Week # 14- Class Presentations & Course Wrap-Up

- **Final Assignment Due**

Appendix (D)

Course Syllabus
Master of Social Work Program
Trauma Informed Care for Military Populations

Instructor	Ken Marfilius, MSW, LCSW	Phone	TBA
Office	TBA	E-mail	TBA
Office Hours	By Appointment	Class Time	

Prerequisite/Co-requisite: None

I. AUDIENCE

This course is designed for graduate students interested in gaining knowledge of trauma informed care for military populations and how to effectively develop trauma informed care communities and trauma specific treatment for military populations.

II. COURSE DESCRIPTION

Trauma informed care for military populations. The course provides an introduction to trauma informed care for military populations, while highlighting the adverse childhood experiences research and post-traumatic stress disorder.

III. ADDITIONAL COURSE DESCRIPTION

The course will analyze the military mental system through clinical case conceptualizations, specifically examining clinical presentations in a military mental health context. The course will concentrate on the topic areas of military sexual trauma, interpersonal violence and combat, military related intimate partner violence survivors, and trauma informed care for homeless veterans. Class sessions will build on knowledge from other courses within the program and integrate experiences from field placements, case conceptualizations, and feedback from peers and instructor.

IV. LEARNING OBJECTIVES

After taking this course, the students will be able to:

1. Develop a working understanding of what is trauma informed care, and how to develop trauma informed communities and trauma specific treatment
2. Demonstrate an understanding of how to develop the skillset to identify and address organizational stress and what creates a trauma informed community
3. Understand the effects adverse childhood experiences and trauma can have on a child's development, behaviors, and eventual adult physical and mental functioning

4. Demonstrate the ability to examine how culture is closely linked with traumatic experiences, responses, and treatment
5. Identify how pre-existing factors, vulnerabilities, and protective factors can influence the adverse impacts of trauma across military populations
6. Distinguish their personal values, understand complex and shared trauma, and how interventions with trauma exposed military populations impact the clinician in working with these populations

V. REQUIREMENTS

A. Bibliography/ Texts / Supplies – Required:

Kraft, H. S. (2007). Rule number two: Lessons I learned in a combat hospital. Little, Brown.

Rothschild, B. (2011). Trauma essentials: The go-to guide. WW Norton & Company.

Other Required Reading:

Required journal articles or chapters ***not in*** the required books above are accessible via

Blackboard.

VI. CLASS ASSIGNMENTS

Assignments are to be submitted to the instructor via email prior to the start of class on the due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date. All papers must be written in APA format, 6th edition.

Class Attendance, Participation, & Discussion Leadership:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussions, and reading leadership.

Assignment 1

Part 1 (10 Points) Blackboard Discussion:

Your class participation through blackboard discussion and reading leadership will be essential to the learning process. These activities are a class requirement and will contribute to your final grade. Students are required to create an original post in response to the appropriate week's readings and engage in commenting on your classmates posts.

Learning Outcomes # 1, 2, 3, 4, 5, 6

Part 2 Reading Leadership (10 Points):

Students will be divided into groups at the beginning of the course. Students will create four class discussion questions based on the required reading(s) for their assigned class session. Each group must present a summary of the assigned readings prior to beginning the class facilitated discussion. Students must submit their questions to the class via email or on blackboard at least two days prior to the relevant class session. In addition to providing a summary and discussion questions, students are encouraged to present any outside material that may be relevant to their assigned readings and advanced clinical practice with military populations.

Learning Outcomes # 1, 2, 3, 4, 5, 6

Assignment 2 (10 pts): Reflection Paper

Students will submit a 5-7 page reflection paper on, *Rule number two: Lessons I learned in a combat hospital*. The reflection paper should focus on topics and themes discussed throughout the course such as; trauma informed care, analyzing and addressing the military system, public health implications of trauma and violence, complex trauma, and shared trauma. A reflection should be completed each week. Each entry should be no more than one page and the final paper will be due by week 7 of the course.

Learning Outcomes: # 1, 4, 5, 6

Assignment 3 (30 pts): Midterm Exam in Class #8

This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Learning Outcomes: # 1, 2, 3

Assignment 4 (40 points): Executive Summary and Presentation

Please refer to the following publications for your executive summary and final presentation:

(1) Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies, Incorporated.

(2) Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Executive Summary (20 points)

The executive summary should be 5-7 pages in length. The intent of the executive summary is to provide a clear and concise written version of your presentation. The goal of the summary is to identify the key ingredients and barriers for successful trauma-informed care implementation at your field placement agency or organization. The first part of the paper should address the system you are analyzing. It should address the history, values, mission, and what you have uncovered about how the system resists change or deals with loss. The paper should also include whether or not the employees and clients feel safe in the environment. Discuss what trauma informed service delivery would mean for clients, staff, and the organization. The executive summary should address the six key principles of trauma informed approach as it pertains to your specific identified agency: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues. The executive summary should also incorporate guidance for your agency on how to implement a trauma-informed approach through use of the ten implementation domains.

Presentation (20 Points)

The presentation portion of the assignment should be of high quality and stem from your executive summary. It should consist of understanding how to effectively implement trauma informed care practices into current agency functioning. The presentation should be clear, concise, and demonstrate the vital importance of having trauma informed organizations. The presentation should be designed for front line supervisors, managers, team leaders, and executive leadership. Presentations will be no longer than 20 minutes in duration.

Below is a guide for your presentation and it is not meant to be exhaustive.

- Provide an overview of trauma informed care.
- Define and provide examples of trauma—Include Adverse Childhood Experiences Literature.
- How do you plan to educate your agency about trauma informed care practices?
- How would you complete a self-assessment of your agency and identify training needs? Explain why this is important.
- Who would conduct the required trainings?
- How would you engage supervisors and executive leadership?
- Explain how you would evaluate the organizations effectiveness of implementing Trauma Informed Practices.
- How would you ensure your agency remains trauma informed care after its initial implementation?

- How would you train new staff and provide booster sessions or continuing education opportunities? Would there be required trainings for all staff?

- Provide a list of Trauma Informed Care resources for your organization.

Learning Outcomes: # 1, 2, 3, 4, 5, 6

Grading:

Assignment one
- Part 1 10 pts
- Part 2 10 pts

Assignment Two: 10 pts
Assignment Three: 30 pts
Assignment Four: 40 pts

Grading System

Letter Grade	Numeric Range
A	92+
A-	88-91
B+	84-87
B	81-83
B-	77-80
C	70-73

Format for Papers: Typed, double spaced, Times New Roman, 12 point font, one-inch margins on all sides, with page numbers. Utilize APA Format for in-text citations and reference list.

Course Specific Policies:

Participation and attendance are mandatory for a satisfactory grade in this course. This course will rely heavily on class participation, discussion, and reading leadership. Students needing to be excused from class must obtain permission from the class instructor. Student participation is a reflection of professional behavior and courtesy. The course instructor expects students to remain focused on course content and routinely engaged in classroom discussion in order to maintain a positive learning environment.

Assignments are to be submitted to the instructor prior to the start of class on the assignment due date. Unless you have been granted prior permission from the instructor, five points will be deducted for each day the assignment is late. Students needing an extension should discuss directly with the instructor at least one week prior to the due date.

Weekly Course Topics and Readings

T=Located in course required textbook(s)

B=Located on blackboard

Week #1- What is Trauma Informed Care: An Introduction and Overview

- **(T)** Kraft: pp. 7-35
- **(B)** Albee, G. W. (1982). Preventing psychopathology and promoting human potential. American psychologist, 37(9), 1043.
- **(B)** Purtle, J. (2014). The legislative response to PTSD in the United States (1989–2009): A content analysis. Journal of traumatic stress, 27(5), 501-508.

Week #2- Adverse Childhood Experiences and Military Service

- **(T)** Kraft: pp. 36-71
- **(B)** Blosnich, J. R., Dichter, M. E., Cerulli, C., Batten, S. V., & Bossarte, R. M. (2014). Disparities in adverse childhood experiences among individuals with a history of military service. JAMA psychiatry, 71(9), 1041-1048.
- **(B)** LeardMann, C. A., Smith, B., & Ryan, M. A. (2010). Do adverse childhood experiences increase the risk of postdeployment posttraumatic stress disorder in US Marines?. BMC Public Health, 10(1), 437.
- **(B)** Montgomery, A. E., Cutuli, J. J., Evans-Chase, M., Treglia, D., & Culhane, D. P. (2013). Relationship among adverse childhood experiences, history of active military service, and adult outcomes: homelessness, mental health, and physical health. American journal of public health, 103(S2), S262-S268.

Week #3- ACES, Combat, and Posttraumatic Stress Disorder

- **(T)** Kraft: pp. 72-113
- **(B)** Cabrera, O. A., Hoge, C. W., Bliese, P. D., Castro, C. A., & Messer, S. C. (2007). Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. American journal of preventive medicine, 33(2), 77-82.
- **(B)** Clancy, C. P., Graybeal, A., Tompson, W. P., Badgett, K. S., Feldman, M. E., Calhoun, P. S., ... & Beckham, J. C. (2006). Lifetime Trauma Exposure in Veterans With Military-Related Posttraumatic Stress Disorder: Association With Current Symptomatology.[CME]. Journal of Clinical Psychiatry, 67(9), 1346-1353.
- **(B)** Sareen, J., Henriksen, C. A., Bolton, S. L., Afifi, T. O., Stein, M. B., & Asmundson, G. J. G. (2013). Adverse childhood experiences in relation to mood and anxiety disorders in a population-based sample of active military personnel. Psychological Medicine, 43(1), 73-84.

Week #4-Analyzing and Addressing the Military System—Public Health Implications of Trauma & Violence

- **(T)** Kraft: pp. 114-149
- **(T)** Rothschild: Introduction-Chapter 4
- **(B)** Bloom, S. L. (1996). Every time history repeats itself, the price goes up: The social reenactment of trauma. Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention, 3(3), 161-194.
- **(B)** Chu, J. A. (1991). The repetition compulsion revisited: Reliving dissociated trauma. Psychotherapy: Theory, Research, Practice, Training, 28(2), 327.

Week #5-Complex Trauma Part 1

- **(T)** Kraft: pp. 150-194
- **(T) Rothschild:** Chapters 5-8
- **(B)** Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. Psychological Trauma: Theory, Research, Practice, and Policy, S(1), 86-100.

Week #6-Complex Trauma Part 2

- **(T)** Kraft: pp. 195-228
- **(T) Rothschild:** Chapters 9-12
- **(B)** Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. Journal of traumatic stress, 18(5), 449-459.

Week #7-Shared Trauma for the Military Clinician

- **(T)** Kraft: 229-243
- **(T) Rothschild:** Chapters 13-16
- **(B)** Tosone, C., Nuttman-Shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. Clinical Social Work Journal, 40(2), 231-239.
- **(B)** Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician?. Professional Psychology: Research and Practice, 42(1), 79.
- **Turn in reflection papers (Assignment 2)**

Week #8- Mid-Term Examination

*****This in class exam covers class discussion, required readings, and lectures. The exam may include a combination of multiple-choice and essay questions. Questions will draw from class discussions, readings, lectures, and handouts.

Week #9- Military Sexual Trauma—A Trauma Informed Care Approach for Military Veterans

- **(B)** Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. American Journal of Public Health, 97(12), 2160-2166.
- **(B)** Maguen, S., Cohen, B., Ren, L., Bosch, J., Kimerling, R., & Seal, K. (2012). Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with posttraumatic stress disorder. Women's Health Issues, 22(1), e61-e66.
- **(B)** Mattocks, K. M., Haskell, S. G., Krebs, E. E., Justice, A. C., Yano, E. M., & Brandt, C. (2012). Women at war: Understanding how women veterans cope with combat and military sexual trauma. Social science & medicine, 74(4), 537-545.

Week #10-Interpersonal Violence & the Military; Trauma Informed Care and Military Related IPV Survivors

- **(B)** Iverson, K. M., Wells, S. Y., Wiltsey-Stirman, S., Vaughn, R., & Gerber, M. R. (2013). VHA primary care providers' perspectives on screening female veterans for intimate partner violence: A preliminary assessment. *Journal of family violence*, *28*(8), 823-831.
- **(B)** Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: interpersonal violence, PTSD, and mental health in women veterans. *Research in nursing & health*, *34*(6), 457-467.
- **(B)** Marshall, A. D., Panuzio, J., & Taft, C. T. (2005). Intimate partner violence among military veterans and active duty servicemen. Clinical psychology review, 25(7), 862-876.

Week #11- Trauma Informed Care for Homeless Veterans

- **(B)** Dinnen, S., Kane, V., & Cook, J. M. (2014). Trauma-informed care: A paradigm shift needed for services with homeless veterans. *Professional case management*, *19*(4), 161-170.
- **(B)** Hamilton, A. B., Poza, I., & Washington, D. L. (2011). "Homelessness and trauma go hand-in-hand": Pathways to homelessness among women veterans. *Women's Health Issues*, *21*(4), S203-S209.
- **(B)** Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3(2), 80-100.

Week #12- Leadership for Change—Part 1

- **(B)** Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies, Incorporated.
- **(B)** Jones, B., & Phillips, F. (2016). Social work and interprofessional education in health care: A call for continued leadership. *Journal of Social Work Education*, *52*(1), 18-29.

Week #13-Leadership for Change—Part 2 & Class Presentations

- **(B)** Sullivan, W. P. (2016). Leadership in Social Work: Where Are We?. *Journal of Social Work Education*, *52*(sup1), S51-S61.
- **(B)** Wolff, T., Minkler, M., Wolfe, S. M., Berkowitz, B., Bowen, L., Butterfoss, F. D., & Lee, K. S. (2016). Collaborating for equity and justice: Moving beyond collective impact. Nonprofit Quarterly, 23(4), 42-53.

Week # 14- Class Presentations & Course Wrap-Up

- **Final Assignment Due**

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